Pharmaceutical Society of Northern Ireland

PERSONAL DETAILS FORM FOR EEA APPLICANTS

PLEASE ENSURE THAT ALL RELEVENT SECTIONS OF THIS FORM ARE COMPLETED.

TITLE

SURNAME

FORENAMES

KNOWN AS

MAIDEN NAME
(IF APPLICABLE)

ADDRESS LINE 1

TOWN

COUNTY

POST CODE

COUNTRY

CORRESPONDENCE ADDRESS
(IF DIFFERENT FROM ABOVE

GENDER

DATE OF BIRTH

HOME TEL NO.

MOBILE

EMAIL ADDRESS
(case sensitive)

PHARMACY
QUALIFICATION

UNIVERSITY

DATE FIRST REGISTERED

REGISTERING BODY

FOR OFFICE USE ONLY

ECCPS RECEIVED

DATE RECEIVED

PLEASE SUPPLY DETAILS OF ALL THE REGULATORY BODIES YOU HAVE BEEN REGISTERED WITH THROUGHOUT YOUR CAREER. (Please note you will need to supply European Certificate of Current Professional Status from each of these bodies).

NAME OF BODY	ADDRESS OF REGISTERING BODY	DATES FROM/TO

ARE YOU A SUPERINTENDENT PHARMACIST?

YES ☐ NO ☐

IF YES
NAME AND ADDRESS OF BODY CORPORATE

SECTION TWO PAYMENT DETAILS

PLEASE TICK THE BOXES TO INDICATE THAT YOU HAVE PAID THE APPROPRIATE FEES

NEW APPLICANT FEE £121 ☐ REGISTRATION FEE £372 ☐

PLEASE NOTE THAT A FEE OF £372 FOR REGISTRATION FOR THE YEAR MUST ALSO BE PAID BEFORE AN APPLICANT CAN JOIN THE REGISTER.

VOLUNTARY PAYMENTS- If you wish to make a contribution to the Benevolent fund please enter the amount in the box provided. If you wish to join/ retain membership with the CPA please provide £15 membership fee and enter into box provided.

BENEVOLENT FUND ☐ COMMON WEALTH PHARMACEUTICAL ASSOCIATION ☐

SECTION THREE EMPLOYMENT DETAILS

MAIN EMPLOYMENT TYPE (PLEASE TICK)

EMPLOYED ☐ SELF EMPLOYED ☐

MAIN EMPLOYMENT AREA (PLEASE TICK)

COMMUNITY	☐	HOSPITAL	☐	INDUSTRY	☐	ADMIN	☐
LOCUM/ HOSPITAL	☐	LOCUM/COMM	☐	ACADEMIA	☐	PRESCRIBING ADVISOR	☐

AVERAGE NUMBER OF DAYS IN EMPLOYMENT PER WEEK ☐

MAIN EMPLOYMENT

NAME AND ADDRESS	EMPLOYER NO.1	EMPLOYER NO.2

INDEMNITY INSURANCE

DO YOU HAVE PERSONAL PROFESSIONAL INDEMNITY INSURANCE COVER? (Please tick) YES ☐ NO ☐
IF YES PLEASE STATE NAME OF INSURANCE COMPANY BELOW

DO YOU HAVE PROFESSIONAL INDEMNITY INSURANCE COVER PROVIDED BY AN EMPLOYER? YES ☐ NO ☐
IF YES PLEASE STATE NAME OF INSURANCE COMPANY BELOW

SECTION FOUR – MAILING OPTIONS AND USE OF DATA HELD

Please note that all members will receive the mailings related to all registration/regulation issues and professional services. The data held regarding you will be stored in both paper and electronic format. The Society is required to maintain and update your registration details on an annual basis and publish a register.

Do you wish to have details of your address supplied to:
Tick box to confirm consent

1. Northern Ireland Centre for Pharmacy Learning and Development ☐

I WISH TO RECEIVE FUTURE CORRESPONDENCE FROM THE SOCIETY PRIMARILY BY EMAIL YES ☐ NO ☐

I AGREE TO MY DETAILS BEING INCLUDED/MAINTAINED ON A REGISTER OF PHARMACISTS WHO ARE WILLING TO SUPPORT PHARMACY SERVICES DURING A 'NATIONAL EMERGENCY' (SUCH AS PANDEMIC FLU)[1] AND TO THIS INFORMATION BEING USED FOR EMERGENCY PLANNING BY THE GOVERNMENT.

YES ☐ NO ☐

Please note a copy of the register is also provided to the Pharmacy Inspectorate at the DHSSPSNI in compliance with the Pharmacy (Northern Ireland) Order 1976.

SECTION FIVE PHARMACIST DECLARATIONS

A CHARACTER DECLARATION

PRINT NAME ______________________

REGISTRATION NUMBER ______________________

Any Pharmacist wishing to register with the Pharmaceutical Society of Northern Ireland must be able to satisfy the Society of his/her good character.

1. **HAVE YOU EVER RECEIVED A CAUTION OR BEEN CONVICTED OF AN OFFENCE WITHIN THE UK OR ELSEWHEREOTHER THAN A MOTORING OFFENCE NOT RESULTING IN DISQUALIFICATION ABOUT WHICH YOU HAVE NOT PREVIOUSLY ADVISED THE REGISTRAR?** YES ☐ NO ☐
   (The position of Pharmacist is exempt from the provisions of the Rehabilitation of Offenders (Northern Ireland) Order 1978. Therefore you must declare all convictions including those that would be considered "spent" under this legislation.)

2. **ARE YOU SUBJECT OF ONGOING OR PENDING CRIMINAL PROCEEDINGS IN THE UK OR ELSEWHERE OTHER THAN A MOTORING OFFENCE NOT RESULTING IN DISQUALIFICATION ABOUT WHICH YOU HAVE NOT PREVIOUSLY ADVISED THE REGISTRAR?** YES ☐ NO ☐

3. **ARE YOU SUBJECT TO ANY FINDINGS OR DETERMINATIONS BY A LICENSING OR REGULATORY BODY IN THE UK OR ELSEWHERE, ABOUT WHICH YOU HAVE NOT PREVIOUSLY ADVISED THE REGISTRAR?** YES ☐ NO ☐

4. **ARE YOU SUBJECT TO SEX OFFENDER NOTIFICATION REQUIREMENTS?** YES ☐ NO ☐

5. **ARE YOU LISTED ON THE DISQUALIFICATION FROM WORKING WITH CHILDREN OR VULNERABLE ADULTS LIST IN NORTHERN IRELAND, RELEVANT SCOTTISH LISTS OR OTHER LISTS HELD BY THE DEPARTMENT OF CHILDREN, SCHOOLS AND FAMILIES AND DEPARTMENT OF HEALTH IN ENGLAND AND WALES?** YES ☐ NO ☐

If your answer is YES to any of the above, please provide details of convictions/proceedings and any evidence that you consider would help support your claim of good character for consideration by the Registrar if not previously supplied. Any information supplied must be marked Confidential and for the attention of the Registrar only.

Please note all fitness to practise information declared, will be referenced on any certificate of current professional status supplied by the Society to another competent authority.

DECLARATIONS BY THE PHARMACIST:

I declare that the information provided above (PARTS 1-5) is true. YES ☐ NO ☐

I declare that I am a suitable person to practise as a Pharmaceutical Chemist YES ☐ NO ☐

[1] Please note this is consent allowing for your current contact details to be supplied to a government agency in a state of national emergency as declared so by the government.

B HEALTH DECLARATION (CONFIDENTIAL)

Principle 6.6 of the Code of Ethics 2009 states that you must:
"Practise only if you are competent and fit to do so. Promptly inform the Society, your employer and other relevant authorities of any circumstances that may call into question your fitness to practise or bring the pharmacy profession into disrepute, including ill-health (which includes chemical dependence), impairing ability to practise."

Are there any issues in relation to your mental or physical health that may impair your fitness to practise that you have not previously advised the Registrar?

PLEASE TICK APPROPRIATE BOX YES ☐ NO ☐

If you are concerned that a physical or mental health problem may impair your ability to practise, you must seek to clarify this with your physician or consultant and make a health declaration in writing to the Registrar. Any information supplied must be marked 'Confidential' and for the attention of the Registrar only. Please note you may be asked to undertake an occupational health assessment commissioned by the Society.

C CPD DECLARATION

Continuing Professional Development (CPD) amounting to 30 hours per year is a professional requirement for all registered pharmacists in Northern Ireland (see principle 6 of the Code of Ethics 2009). The Society currently only has one category of membership for pharmacists who practise in Northern Ireland i.e. practising.

Continuing Professional Development (CPD) amounting to 30 hours per year is a professional requirement of all registered pharmacists in Northern Ireland.

DECLARATION BY THE PHARMACIST:
I understand, that I am required to complete 30 hours of CPD or the proportionate amount to satisfy my professional requirement for the year (Please tick box to confirm) ☐

D DECLARATION BY APPLICANT

I DECLARE THAT:

ALL OF THE INFORMATION I GIVE IN THIS FORM AND IN ANY SUPPORTING DOCUMENTS IS ACCURATE.

I WILL COMPLY WITH THE CODE OF ETHICS PUBLISHED BY THE SOCIETY'S COUNCIL.

I UNDERSTAND AND I AM ABLE TO UNDERTAKE THE RESPONSIBILITIES OF A REGISTERED PHARMACIST, WHICH I ACKNOWLEDGE MAY INCLUDE TAKING SOLE CHARGE OF A COMMUNITY OR HOSPITAL PHARMACY AND THE PROVISION OF ADVICE IN RELATION TO THE SCIENCE OF MEDICINES OR THE PRACTISE OF PHARMACY OR HEALTHCARE.

I ACKNOWLEDGE AND UNDERSTAND MY OBLIGATIONS WHEN WORKING IN A REGISTERED PHARMACY, AS DETAILED IN THE HEALTH ACT 2006 AND THE MEDICINES (PHARMACIES) (RESPONSIBLE PHARMACIST) REGULATIONS 2008.

I UNDERSTAND MY OBLIGATIONS AS DETAILED IN THE SUPPLEMENTARY PROFESSIONAL STANDARDS AND GUIDANCE PUBLISHED BY THE SOCIETY.

I HAVE A DUTY TO NOTIFY THE REGISTRAR OF ANY CHANGES TO MY NAME, HOME ADDRESS OR OTHER CONTACT DETAILS.

I HAVE A DUTY TO NOTIFY THE REGISTRAR OF ANY FITNESS TO PRACTISE MATTERS WITHIN 7 DAYS OF ANY OCCURRENCE THROUGHOUT REGISTRATION YEAR (1ST JUNE TO 31ST MAY)

IF I AM FOUND TO HAVE GIVEN FALSE OR MISLEADING INFORMATION IN CONNECTION WITH MY REGISTRATION, THIS MAY BE TREATED AS MISCONDUCT FOR THE PURPOSES OF THE PHARMACY(NI) ORDER 1976, WHICH MAY RESULT IN MY REMOVAL FROM THE REGISTER.

DATA PROTECTION STATEMENT

The information that you provide in sections 1 to 5 of this form will be held by the Pharmaceutical Society of Northern Ireland to process your application and for regulatory purposes. It will be held securely at all times in accordance with current data protection legislation.

The information provided may be used to contact you with regulatory and professional information, for example, information to assist you in complying with new legislation, regulation or Professional Standards and Guidance, or notice of events.

In line with the Data Protection Act 1998, we may also share your information with other agencies for regulatory purposes e.g. the Police Service, the Courts Service and the Inspectorate of the Department of Health, Social Service and Public Safety.

SIGNED		DATE	
PRINT NAME		REGISTRATION NUMBER	

FOR OFFICE USE

Retention ☐ Benevolent ☐ Association ☐ Input to Database ☐