

PHARMACY COUNCIL

MINISTRY OF HEALTH

Request for Certificate of Good Standing

(Please Print Information Clearly)

FIRST NAME: MIDDLE NAME:

SURNAME: MALE: FEMALE:

DATE OF BIRTH: (DD/MM/YY)

PROFESSION:

DATE OF FIRST REGISTRATION:

MAILING ADDRESS:

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TELEPHONE NO.: (W) (H) (C)

EMAIL ADDRESS:

FORWARDING ADDRESS FOR CERTIFICATE OF GOODSTANDING:

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BASIC QUALIFICATION:

DATE OBTAINED:

UNIVERSITY / COLLEGE:

SIGNATURE: DATE: