PHARMACY COUNCIL

Registrar
Pharmacy Council
P. O. Box 31818
DAR ES SALAAM

PASSPORT PHOTO

APPLICATION FOR PROVISIONAL REGISTRATION AS AN INTERN PHARMACIST

(Section 18 (1) and (2) of the Pharmacy Act, Cap 311)

PART I : (To be completed by the applicant)

1. Full Name: ---------- ----------
   First *Middle* *Last*

2. Address: ----------

   (i) Permanent: ----------

   (ii) Temporary: ----------

   (iii) Mobile No:---------- Email address ----------

3. Date of Birth: ---------- Nationality----------

4. Qualification: ----------

5. Awarding University/College ----------(Year)----------

PART II: EDUCATION BACKGROUND

I, ----------do solemnly affirm as follows:

a) That I have attended training and attained the qualification stated hereunder:

Training institution	Course Pursued	Duration of Training	Qualification attained

b) That I have worked in the following places since qualifying:

No.	Name of Institution	Address
1.		
2.		
3.		

c) That the attached certified copies of documents relating to my training (degree, certificate, diploma etc.) are true copies of the original:

1.	
2.	
3.	
4.	
5.	

d) And solemnly make this declaration, conscientiously believing the same to be true and I am aware that false statement may lead to legal action taken against me.

…… ……

Signature **Date**

This form is to be submitted with the following documents for Provisional Registration:-

S/N	***Supporting documents Submitted***	***Original***	***Copy***
1.	Certified copy of Certificate of Evaluation of Award from Tanzania Commission for Universities *(graduates from abroad)*		
2.	Certified copy of your University Academic transcripts		
3.	Certified copy of your University degree		
4.	Certified copy of your A' level & O'level certificates		
5.	Certified copy of your Birth certificate		
6.	Certified copy of any other relevant certificate		
7.	Current four (4) colored passport sizes (2x2.5cm) or stamp size		
8.	Evidence of payment of 75$ as prescribed in the Registration Regulations, 2005		

NOTE:

(i) Documents which are not in English Language must be interpreted by a recognized authority and attached to the documents of the original language

(ii) All Council fees and charges are to be paid at Pharmacy Council Bank Account (CRDB AZIKIWE ACCOUNT NUMBER 01J1028116700 or NBC MLIMANI CITY BRANCH ACCOUNT NUMBER 053103000318)

PART IV
(For Official use only)

This application has been approved/rejected for the following reasons:

…… **……**

Signature of Registrar **Date**

APPENDIX: INTERNSHIP PLACEMENT

No.	Name of the Internship Centre	Select three (3) Intern Centers for consideration
1.	Aga Khan Hospital - Dar – es Salaam	
2.	Amana Hospital - Dar – es Salaam	
3.	Bombo Regional Hospital – Tanga	
4.	Bugando Medical Centre - Mwanza	
5.	Hydom Lutheran Hospital - Manyara	
6.	Iringa Regional Hospital – Iringa	
7.	Jakaya Kikwete Heart Institute - Dar es Salaam	
8.	Kilimanjaro Christian Medical Centre - Moshi	
9.	Ligula Regional hospital – Mtwara	
10.	Mawenzi Regional Hospital - Moshi	
11.	Mbeya Referral Hospital – Mbeya	
12.	Mbeya Regional Hospital – Mbeya	
13.	Mount Meru Regional Hospital - Arusha	
14.	Muhimbili National Hospital - Dar es Salaam	
15.	Mwananyamala Hospital - Dar es Salaam	
16.	Ocean Road Hospital - Dar es Salaam	
17.	Pharmacy Council – Headquarters- Dar es Salaam	
18.	Sekou Toure Regional Hospital - Mwanza	
19.	Shely's Pharmaceutical Industry Ltd - Dar es Salaam	
20.	Shinyanga Regional Hospital - Shinyanga	
21.	Sinza Hospital - Dar es Salaam	
22.	Songea Regional Hospital - Ruvuma	
23.	Tanzania Food and Drugs Authority (TFDA) – Headquarters - Dar es Salaam	
24.	Temeke Hospital - Dar – es Salaam	
25.	Tumbi Hospital – Kibaha	