THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

PHARMACY COUNCIL

APPLICATION FORM FOR APPROVAL OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROGRAM

Made under The Pharmacy (Education and Training) Regulations, 2005 G.N 333.

PART I: CPD PROVIDER'S INFORMATION

1. Name of CPD Provider: --
2. Name of contact Person -------------------------Mobile No: ---------
3. Qualifications (contact person) -------------------------------------
4. Physical address; Country --Region/state -------------
5. Postal address: --------------------Tel No: -----------------------
6. Email address: --

PART II: CPD PROGRAM INFORMATION (*attach CPD program contents*)

1. Name of CPD Program(s); --

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2. Intended Leaners; --
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3. Professional competence (s) intending to improve;

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4. Mode of Delivery; ----------
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5. Proposed duration; ----------

6. Place (Venue) if applicable; ----------

7. Name(s) and Qualification of CPD Presenter (s); (attach CV)

   i. ----------

   ii. ----------

   iii. ----------

   iv. ----------

   v. ----------

8. Declaration of conflict of interest; ----------

PAYMENT

Control Number: _____ Amount paid: _____

Name of applicant: _____Signature: _____

Date: _____

PART III: OFFICIAL USE

1. Approval of CPD programs;

S. N	CPD Program Name	Approval Status	Awarded Points
1.			
2.			
3.			
4.			
5.			

2. Signature of Registrar/ Authorization: ----------Date: ----------

Official Stamp