THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

PHARMACY COUNCIL

APPLICATION FORM FOR APPROVAL AS A CPD PROVIDER

Made under Regulation 59 of 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:__________________________Tell No:____________________
6. Email address ____

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

1. Name of CPD Program(s); ____

   _

   _

   _

   _

   Intended Leaners: ____

   _

   _

2. Professional competence (s) intending to improve;

   ---

3. Mode of Delivery; _____

   ---

4. Proposed duration; _____

5. Place (Venue) if applicable; _____-----_____

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

   i. _____
   ii. _____
   iii. _____
   iv. _____
   v. _____

PART III : ATTACHMENTS

Institutional profile / Individual curriculum vitae

PART III: PAYMENT FEE

Payment control No..... Date of Payment:.....

PART IV: DECLARATIONS

Declaration of conflict of interest: ____

____

Name:________________________Signature: _________________________

Date: _______________________

PART III: OFFICIAL USE

1. Approval/ Disapproval of the CPD Provider: --

2. Reason(s) for Approval /Disapproval of CPD Provider: ----------------------------------
   -
   -
3. Approval of CPD programs;

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

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

Official Stamp