## CPD PROVIDER APPLICATION FORM

1. **Identification**

|  |  |
| --- | --- |
| Name of the provider: | |
| Country: | Telephone No: |
| City: | E-mail address: |
| P.O.Box: | Website: |

1. **Category of the provider (Tick as appropriate)**

|  |  |  |
| --- | --- | --- |
| 1 | Individual |  |
| 2 | Public |  |
| 3 | Private(for profit) |  |
| 4 | Other |  |
| 5 | NGO |  |

1. **Type of accreditation requested (Tick as appropriate)**

|  |  |
| --- | --- |
| Pharmaceutical (applied) sciences |  |
| Supply chain management and logistics |  |
| Administration/Management |  |
| Information and Communication Technology in Pharmaceutical Sciences |  |
| Pharmaceutical laws, policies & ethics |  |
| Research |  |
| Pharmacy practice |  |
| Others (Specify) |  |

1. **Evidence of previous performance or training activities (to be attached) (If any)**

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1. **List of prospective persons to deliver CPD activities**

(Attach notified copies of the degree, evidences of qualifications and expertise).

*Notice: All facilitators involved must hold current* ***licence to practice (where applicable).***

|  |  |  |
| --- | --- | --- |
| **Names** | **Qualification** | **Council Registration number (where applicable)** |
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|  |  |  |

**Representative names Signature and stamp**

**………..……………………………………………… ………………….………………………………….**

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| --- |
| **FOR NPC OFFICE USE ONLY**  I certify that.................................................................................................fulfilled/has not fulfilled the requirements for the purpose of serving as a **CPD** Provider in the area of……………………………………………………………..  **Reviewed by the in charge of CPD Date**  **............................................................................................................................ ..…………………**  (Signature)  **Approved by the Permanent Secretary Date**  **............................................................................................................................ ..…………………**  (Signature) |