Health Status Form - [for the purposes of registration as a pharmacist]

Declaration by Applicant

(to be signed by the applicant in the presence of the registered medical practitioner)

I, the undersigned, wish to undergo a medical examination for the purposes of obtaining registration as a pharmacist, which may include taking sole charge of a community or hospital pharmacy

Name of Applicant:
(Name in full as it appears on the birth/marriage certificate)

Of:
(Address of applicant)

_____

_____

_____

_____

Date of birth: _____

Signed: _____ *Date:* _____

(Signature of Applicant)

Medical Practitioner Certification

To: The Registrar, Pharmaceutical Society of Ireland, PSI House, Fenian Street, Dublin 2, Ireland

I, the undersigned registered medical practitioner, hereby certify that:-

- The applicant has signed the above declaration in my presence
- I have examined the applicant with regard to his/her physical and mental health

My opinion as to the state of the applicant's physical or mental health is as follows:-

The examination did not disclose any reason on grounds of physical or mental health why he/she should not be able to discharge the responsibilities of a registered pharmacist.

Yes ☐ No ☐

If **No –** state reasons below:

_____

_____

_____

Signed: _____ Date: _____

(Signature of Medical Practitioner)

Print Name: _____

Registration Number: _____

Practice Address: _____

_____

_____

Telephone: _____

Official Surgery Stamp