

RPBSI.2016.003

Appointment of a Superintendent Pharmacist

Appointment of the Pharmacist by the Pharmacy Owner
as required under Sections 27 (b) & 29 (b) of the Pharmacy Act 2007

Section A : General Information

Section A.1: Pharmacy Owner Details

Type of Pharmacy Owner	Sole Trader <input type="checkbox"/>
	Partnership <input type="checkbox"/>
	Representative <input type="checkbox"/>
Name of Pharmacy Owner(s)	
Registered Address	
Address for Correspondence (if different from Registered Address)	

Section A.2: Details of each Retail Pharmacy Business to which this statement relates (Append a list if necessary)

Trading Name: _____ Company Name: _____	Address: _____ _____
Trading Name: _____ PSI Reg No: _____	Address: _____ _____
Trading Name: _____ PSI Reg No: _____	Address: _____ _____

Section B: Declaration of the Pharmacy Owner continued

Signed:	Print Name: _____ Capacity of Signatory: _____
Signed:	Print Name: _____ Capacity of Signatory: _____
Date:	

Section C: Declaration by the Superintendent Pharmacist

I, _____ being a registered pharmacist with registration no. _____
 [Name as it appears on the Register of Pharmacists]

DECLARE that:

1. I have been appointed by the aforementioned pharmacy owner(s) as the pharmacist for the purposes of Sections 27(b) and 29(b) of the Pharmacy Act 2007 in respect of the Retail Pharmacy Business(es) to which this Statement relates.	
2. I, as such pharmacist, am aware that the part of the business that consists of the management and administration of the sale and supply of medicinal products will be under my personal control, and I undertake to discharge that responsibility.	
3. I am a registered pharmacist with a minimum of 3 years' post-registration experience, as at the date of assuming the position of Superintendent Pharmacist, as set out in Section 25(2) ¹ of the Pharmacy Act 2007 and as required by such a pharmacist under the said Act.	
4. The Retail Pharmacy Business(es), to which this statement relates, will be conducted in compliance with the provisions of the Pharmacy Act 2007 and the Regulation of Retail Pharmacy Businesses Regulations 2008 (S.I. No. 488 of 2008).	
5. I am aware of the legal responsibilities of such a pharmacist under the Pharmacy Act 2007 and Regulations made under Section 18 of the Act and I undertake to use my best endeavours to ensure compliance therewith and with any Regulations, Codes of Conduct, Statutory Rules and professional guidelines as may, for the time being, be in force.	
6. I am aware that if there is any change to the Retail Pharmacy Business or of the list of Retail Pharmacy Businesses listed in this application, in respect of which I act as Superintendent Pharmacist, then I undertake forthwith to notify the PSI in the event of such change.	
Signature of Superintendent Pharmacist:	
Date you are assuming the position of Superintendent Pharmacist:	
Professional Contact Address:	
Mobile Number of Superintendent Pharmacist:	

¹ Section 25(2) - "3 year minimum post-registration experience means experience of at least 3 years of-

(a) practising whole-time as a registered pharmacist—

(i) in a retail pharmacy business,

(ii) before the commencement of this Act, in a shop kept open for the dispensing or compounding of medical prescriptions and the sale of poisons, or

(iii) in a combination of both, or

(b) practising whole-time as a pharmacist outside the State in a business corresponding to a retail pharmacy business on foot of a qualification which was (or could have been) the qualification appropriate for practice by reference to which he or she has registered under this Act, or

(c) any combination of the types of experience set out in paragraphs(a) and (b)

Fee Payment - Change of Superintendent Pharmacist

- The application fee for Change of Superintendent/Supervising Pharmacist is €85.
- Please complete the section below, and enclose the application fee.

Trading Name of Pharmacy			
Pharmacy Registration Number			
Address of Pharmacy			
Payment Method (please tick as appropriate)	• Postal Order/Bank Draft/Cheque (please attach) <i>Made payable to The Pharmaceutical Society of Ireland</i>	<input type="checkbox"/>	
	• Credit/Debit Card (complete section below)	<input type="checkbox"/>	

Card Payment Details

Card Type	Visa	<input type="checkbox"/>	MasterCard	<input type="checkbox"/>
Cardholder Name				
Card Number				
Expiry Date				
Security Code				

I authorise the PSI to charge the above card with the following amount: €85

Signature of Cardholder: _____ **Date:** _____

Please return the application to:
Inspection & Enforcement Unit
The Pharmaceutical Society of Ireland
PSI House, Fenian Street,
Dublin 2, D02 TD72

Telephone: (01) 218 4000
Website: www.psi.ie