The College of Pharmacy Practice Limited

Application Form
Advanced Pharmacotherapy Workshop for Pharmacists

A. Personal Particulars

Surname: _____ Given name: _____

Name in Chinese (if applicable) : _____ *Title: ☐ Mr. ☐ Ms. ☐ Miss ☐ Other _____

Current job position: _____

Institution: _____

Year(s) of working experience: _____ Pharmacist registration license number: _____

Corresponding address in English: _____

_____

_____

Contact No.: _____ (Mobile) _____ (Office)

E-mail: _____

Reasons for taking this workshop? ☐ BCPS exam preparation ☐ Knowledge refreshment

☐ Other: _____

B. Declaration

1. I authorize The College of Pharmacy Practice to use my data to carry out necessary verification on my application for enrolment.
2. I understand that, upon my registration in a programme, the data will become part of my student record and may be used for purposes relating to my studies in accordance with the procedures of the College of Pharmacy Practice.
3. I declare that the information given in support of this application is accurate and complete, and understand that any misrepresentation will result in disqualification of my application and subsequent enrolment.

_____ _____

Signature Date

Note

1. Please kindly mail the application form with a crossed cheque (payable to the College of Pharmacy Practice Limited) to Rm 801, Lo Kwee-Seong Integrated Biomedical Sciences Building, Area 39, Shatin, N.T., CUHK before 4th July, 2014.
2. **All registrants will be provided with a complimentary membership of the College of Pharmacy Practice (valid until 31st December, 2014)**