PHARMACY COUNCIL OF THE GAMBIA
No. 112 Kairaba Avenue
Fajara , KMC
Tel: 4495572, 2022272 P.O.Box 4527 Bakau
Website: www.gpc.gm

DATA RETURN

This form must be completed and signed by the person responsible for providing training courses accredited by the Pharmacy Council, The Gambia (PCG) accordingly.

A) PARTICULARS OF THE PROVIDER

NAME OF INSTITUTION	NAME OF SCHOOL/FACULTY/COLLEGE

NAME OF RESPONSIBLE PERSON FOR TRAINING COURSES

TELEPHONE NUMBER		E-MAIL ADDRESS
Landline Mobile		

B) PROVIDER SUMMMARY SHEET

Do you/your institution provide programmes for (select all that apply):

A. ☐ Students to become Pharmacists

B. ☐ Students to become Pharmacy Technicians

C. ☐ CPD for Pharmacists

D. ☐ CPD for Pharmacy Technicians/Nurse Dispenser

E. ☐ CPD for Pharmacy Assistants

How long do you/does your institution provide the programmes?

A. _____ number of years

B. _____ number of years

C. _____ number of years

D. _____ number of years

E. _____ number of years

Provide details of any significant changes in the previous three years in ownership, management, premises or academic programme or state "Not applicable" if no changes occurred.

C) DATA COLLECTION

1. Attach a list of the courses offered in the previous three years, including the level of the course and the name of the awarding body, if applicable and different from the institution.

2. Provide details of courses as attachment offered in the previous three years, including numbers enrolled on each course, cohort progression, numbers completing and pass rates in any examinations taken.

3. Outline planned developments

4. Provide details of the institution's quality assurance systems and any changes that have been made to enhance the quality

E) DOCUMENTS SUBMITTED WITH THIS REPORT

DOCUMENTS	CONFIRMED by PCG
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Attestation Statement

As the Responsible Person for Training Courses accredited by Pharmacy Council, The Gambia I/we attest to continue to accept the terms and conditions as outlined in the PCG *Guideline for Accreditation of Training Courses*. We acknowledge that the Council may request to review and evaluate the entire documentation or specific sections at any time, as part of the assessment or as a component of a subsequent monitoring process or for any exigent event.
I, the undersigned certify that the information in this form and the accompanying documentation concerning the application for accreditation of training courses indicated herein is correct and true.

Signature	Date

OFFICIAL USE

DATE OF RECEPTION:		**STAMP**
NAME OF RECEIVER:		
NAME OF REGISTRAR		
REMARKS/RECOMMENDATIONS BY REGISTRAR		
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Signature: ..... **Date:**		