PHARMACY COUNCIL OF THE GAMBIA
Pipeline, off-Kairaba Ave – opposite Mosque
Serrekunda
Tel: +220 438 3841, +220 738 2655/769 0904
P.O.Box 4527 Bakau
Website: www.gpc.gm

PHARMACY INTERNSHIP REGISTRATION APPLICATION

Pharmacist ☐ **Pharmacy Technician ☐** **Pharmacy Assistant ☐**

Fresh graduate in The Gambia ☐ **Fresh graduate abroad ☐** **Practice abroad ☐**

A. PARTICULARS OF APPLICANT

SEX: **Male ☐** **Female ☐**

TITLE [ ] **(Ms, Mr, Mrs, Pharm, Dr, Prof)**

FAMILY NAME/SURNAME	**FORMER/MAIDEN NAME (if any)**

FIRST NAME(S)

DATE OF BIRTH (DD/MM/YYYY)	**NATIONALITY**

	RESIDENTIAL ADDRESS	**POSTAL ADDRESS**
H/No.: Street No./Name Town/Area**:**		

TELEPHONE NUMBER		**E-MAIL ADDRESS**
Landline Mobile		

B PROFESSIONAL EDUCATION OF APPLICANT

BASIC PROFESSIONAL EDUCATION

Type of degree/ Title on the certificate	
Name of University/Institution	
Country of University/Institution	
Date of Entry	
Date of Graduation	

DOCUMENTATION PROVIDED

DOCUMENTS	SUBMITTED by applicant	CONFIRMED by PCG
Application form (signed and dated)	☐	☐
Copy of ..... for identification	☐	☐
A current (not older than one year) CV, signed and dated	☐	☐
Copy of Pharmacy Degree Certificate/ Certificate/Diploma or attestation	☐	☐
Evidence of qualification to practice in the country of training (if trained abroad)	☐	☐
Contact details of the awarding training institution (Gambians trained abroad)	☐	☐
Other (please specify):	☐	☐

C INTERNSHIP PROGRAMME

HOSPITAL PHARMACY PRACTICE

Apart from the teaching hospital, indicate proposed general hospital for the internship

PREFERENCE	REGION	PROPOSED HOSPITAL
1st choice		
2nd choice		
3rd choice		

COMMUNITY PHARMACY PRACTICE

Indicate in order of preference proposed facilities for the community pharmacy practice for the internship

PREFERENCE	REGION	PROPOSED PHARMACY
1st choice		
2nd choice		
3rd choice		

(NOTE: The Pharmacy Council cannot guarantee that applicants will be posted to institutions of their choice)

DECLARATION:

I, the undersigned certify that the information in the accompanying documentation concerning the application for registration indicated herein is correct and true.

Signature of Applicant: ..... **Date:** .....

OFFICIAL USE

DATE OF RECEPTION:		**STAMP**
NAME OF RECEIVER:		
NAME OF REGISTRAR		

Applicant posted to:	**Name of institution**	**Dates (From – To)**
Teaching Hospital:	Edward Francis Small (EFSTH)	.....
General Hospital:	.....	.....
Community Practice:	.....	.....
Advanced institutional rotation	.....	.....
	.....	.....
	.....	.....
	.....	.....

Signature: ..... **Date:** .....