GOVERNMENT OF BERMUDA

MINISTRY OF HEALTH

BERMUDA PHARMACY COUNCIL
APPLICATION FOR REGISTRATION

Please print all information. Complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions attach additional sheets with typed responses.

SECTION 1. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Name: _____
Last *First* *Middle*

Age: _____ Date of Birth: _____ Nationality: _____

Sex: Male ☐ Female ☐

SECTION 2. HOME ADDRESS

Address: _____

_____

Telephone Number: _____ E-mail Address: _____

SECTION 3. BUSINESS ADDRESS

Address: _____

_____

Telephone Number: _____ E-mail Address: _____

Facsimile Number: _____

SECTION 4. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing a tick (✓) in the appropriate box. This will be the address that all future correspondence will be mailed.

Home ☐ Business ☐

SECTION 5. EDUCATION (Indicate all institution of higher education, including institution granting the degree/diploma in pharmacy).

College, School, City, Country **Date of Graduation** **Diploma or Degree**

_____

_____

Other Professional Degrees or Specialty Qualifications (Indicate Date Granted)

_____ _____

_____ _____

SECTION 6. SCREENING QUESTIONS – Answer all of the following questions.

*Answer the following questions by placing a tick (✓) in the appropriate box. If you answer "yes" to questions 2-6 provide complete details **on a separate sheet of paper** and attach to this form. Sign and date below*

		Yes	No
1.	Do you hold licensure or are you registered (active or inactive, current or expired) to practice in any other jurisdiction? If yes, list each one.		
2.	Have you ever withdrawn an application for registration, had an application denied or refused, or agreed not to reapply for registration in another country?		
3.	Has any disciplinary action been taken against you by any licensing authority?		
4.	Have you had privileges denied, revoked or restricted in a hospital or other health care facility?		
5.	Have you been convicted, found guilty, or pleaded guilty or nolo contendere to any offence?		
6.	Do you have a physical or medical condition that currently impairs your ability to practice medicine?		
7.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs?		
8.	Do you have malpractice insurance or are you a member of a medical protection society?		

SECTION 7. SIGNED STATEMENT

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements may result in the revocation of my registration.

Dated this ____ day of _____ 20 ___ _____

Signature of Applicant

"I was provisionally registered as a member of the Bermuda Pharmaceutical Association on the _____ day of _____ 20___"

Application Fee: BD$53.00 (US$53.00). Do not send cash. Make check or money order payable to the **Accountant General**.

FOR OFFICIAL USE ONLY

Fee paid: ☐ Yes ☐ No

Receipt no: _____

Administrative Assistant: _____ DATE: _____

COMMENTS: _____

MEETING MEMBERSHIP:	**NAME**	**PRESENT YES**	**PRESENT NO**	**DATE**
COUNCIL				
CHAIRMAN		☐	☐	
MEMBER		☐	☐	
MEMBER		☐	☐	
MEMBER		☐	☐	
MEMBER		☐	☐	

☐ **APPLICATION APPROVED** ☐ **APPLICATION NOT APPROVED**

Chairman: _____ DATE: _____

Mailing Address:
Bermuda Pharmacy Council,
Ministry of Health
P.O. Box HM 1195
Hamilton HM EX.
Bermuda

Courier Delivery Address:
Bermuda Pharmacy Council
Continental Building
25 Church Street
Hamilton HM12
Bermuda.