# THE PHARMACY COUNCIL

## REINSTATEMENT FORM

Pharmacist's Name: _____
*LAST* *MIDDLE* *FIRST*

Pharmacist's Registration #:_____

Gender: **(MALE/FEMALE)** _____ Date of Birth: _____
*(YEAR-MONTH-DAY)*

Current Address: _____

_____

_____

_____

Telephone Number(s): _____

Email Address: _____

_____

**I hereby declare that I have completed all the requirements for reinstatement on the Register of Pharmacists in Jamaica.**

**Signed by:** _____
*Pharmacist Applying for Reinstatement*

**Signed by:** _____
*Preceptor/Reg. No.*

| LOCATION | SUPERVISING PHARMACIST | PERIOD |
|---|---|---|
| | | |
| | | |
| | | |

**FOR OFFICIAL USE ONLY**

*RECEIVED BY:* _____ *DATE RECEIVED:* _____

*APPROVED BY:* _____

***(REGISTRAR, PHARMACY COUNCIL OF JAMAICA)***

***TABLED** AT A MEETING OF THE PHARMACY COUNCIL OF JAMAICA ON:* _____

***APPROVED** AT A MEETING OF THE PHARMACY COUNCIL OF JAMAICA ON:* _____