



CPD PROVIDER APPLICATION FORM

1. Identification

Name of the provider:	
Country:	Telephone N°:
City:	E-mail address:
P.O.Box:	Website:

2. Category of the provider (Tick as appropriate)

1	Individual	
2	Public	
3	Private(for profit)	
4	Other	
5	NGO	

3. Type of accreditation requested (Tick as appropriate)

Pharmaceutical (applied) sciences	
Supply chain management and logistics	
Administration/Management	
Information and Communication Technology in Pharmaceutical Sciences	
Pharmaceutical laws, policies & ethics	
Research	
Pharmacy practice	
Others (Specify)	

4. Evidence of previous performance or training activities (to be attached) (If any)

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5. List of prospective persons to deliver CPD activities

(Attach notified copies of the degree, evidences of qualifications and expertise).

*Notice: All facilitators involved must hold current **licence to practice (where applicable)**.*

Names	Qualification	Council Registration number (where applicable)
1.		
2.		
3.		
4.		
5.		
6.		

Representative names

Signature and stamp

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FOR NPC OFFICE USE ONLY

I certify that.....fulfilled/has not fulfilled the requirements for the purpose of serving as a CPD Provider in the area of:

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Reviewed by the in charge of CPD

Date

.....
(Signature)

Approved by the Permanent Secretary

Date

.....
(Signature)