The Commonwealth of The Bahamas

BAHAMAS PHARMACY COUNCIL

P.O. Box N-4460
Nassau, Bahamas

GUIDELINES FOR APPLICATION

Please tick ☑ appropriate box to ensure that all information (notarized copies or originals) is submitted

- Application fully completed by Factory/Warehouse Owner ❑

All personal information required on behalf of licensed Pharmacist-in-Charge

- Identification (copy of Birth Certificate **or** Passport **or** NIB Card **or** Driver's License) ❑
- Passport size photograph ❑
- Health Certificate ❑
- Current Police Record ❑
- Notarized copies of Pharmacy Qualifications, if originals cannot be presented for verification ❑
- Notarized copy of Current Registration/Licensure Certificate where applicable ❑
- Evidence of other Registration/Licensures eg. US, Canadian, United Kingdom or Jamaica ❑
- Certificate of Good Standing (Only original documents accepted from relevant Licensing Authority attesting to whether or not the applicant has ever been subject to disciplinary enquiry). ❑
- Four (4) references (written)
  - Professional (2) ❑
  - Character (2) ❑
- Detailed Curriculum Vitae (including Full Pharmacy Education and Post-Graduate Training, Post-Graduate Qualifications, Clinical Experience, Employment History and any Research Work) ❑

<u>**Non-Bahamians**</u>

- Please provide a letter from the employing institution confirming an offer of employment and describing the post offered to you. Letter must be received by Council prior to applicant assuming duties.

- Document certifying citizenship status, (eg. Copy of relevant parts of Passport or Permanent Residency Certificate or Work Permit)

<u>**PLEASE NOTE**</u>**:**

(a) **FAILURE TO PROVIDE ALL OF THE ABOVE DOCUMENTS WILL RESULT IN REJECTION OF THE APPLICATION.**

(b) If approved, Certificate of Registration and Licence will only be issued upon payment of prescribed fees.

FORM 7 REGULATIONS 11(1)

BAHAMAS PHARMACY COUNCIL

APPLICATION FOR LICENSE OF A MANUFACTURER OR WHOLESALER UNDER SECTION 36 OF THE ACT

Licence Fee $________

❑ New Application ❑ Renewal Application

Section 1 - Particulars of Applicant

First Name	Middle Name	Last Name	Suffix (Jr., Sr., III, IV, etc)
National Insurance Number/Country I.D. No.:		Place and Date of Birth (City & State/Country):	

Section 2 - Contact Information for Applicant

P.O. Box:	Home Address (Name of Street, Area & House #):	Email Address:
Place of Employment & Address:		City/Island/Country:
Home Telephone	Work Telephone	Other Telephone (Cell)

Section 3 - Education of Manufacturing/Distribution Supervisor

Name of College/University/Institution attended for Pharmaceutical Studies:	Type of Degree or Certificate Conferred:
Address of Institution:	Date Degree or Certificate Conferred:
List higher qualifications and address: (Attach additional pages if necessary)	
Name & Address of Institution:	

Professional Qualifications:	Date Obtained:

Section 4 – Manufacturer or Wholesaler Information

Name of Factory or Warehouse:		
Street Address of Factory or Warehouse:	City/Island/Country:	
Email:	Phone No.:	Fax No.:
Expected date of opening/ownership transfer:	Copy of Inspector's Report attached: ☐	
Supervisor/Licensed Pharmacist-in-charge:	Licence #:	
Will/does this factory or warehouse engage in sterile product compounding?	Yes: ____________ No: ____________	

Section 5 - Other Licences/Registration(s)

Have you EVER been licensed, registered, certified or otherwise approved to practice as a pharmacist or assist in the practice of pharmacy in any other jurisdiction?			
☐ Yes	Please list each jurisdiction. Attach additional pages, if necessary. Contact each jurisdiction and request that they provide the Bahamas Pharmacy Council with a letter stating the current status of your credentials with them. The letter must also state whether or not you have ever had disciplinary action taken against you.		
☐ NO	Proceed to Section 5		
Credentials #:	Type or Credential:	Credential Issued by:	
Has there been disciplinary action taken against this license? ☐ No ☐ Yes		Initial License Date:	Expiration Date:
Credentials #:	Type or Credential:	Credential Issued by:	
Has there been disciplinary action taken against this license? ☐ No ☐ Yes		Initial License Date:	Expiration Date:

Section 6 - Impairment and/or Drug/Alcohol Addition(s)

Question	Answer
Have you **EVER** habitually used or been diagnosed as addicted to drugs or alcohol?	☐ No ☐ Yes
Have you **EVER** been diagnosed with or do you have any physical or mental impairment, which may affect your ability to practice safely as a Pharmacist?	☐ No ☐ Yes

Section 7 - Criminal Activity/Disciplinary Action

Note: Failure to disclose criminal history may result in the denial or your application, even if the records have been expunged.

Question	Answer
Have you **EVER** been arrested in any jurisdiction?	☐ No ☐ Yes
Have you **EVER** had any disciplinary or adverse action taken against you by any other government or law enforcement agency or court in any jurisdiction?	☐ No ☐ Yes

Are you currently charged with the commission of an offence in any jurisdiction?	☐ No ☐ Yes
Have you **EVER** been convicted of an offence in any jurisdiction?	☐ No ☐ Yes

If you answer "Yes" to **ANY** of the questions in Section 7, you must attach a letter of explanation and a **CERTIFIED COPY** of the court judgment in the case for **EACH** incident. If charges were dismissed, provide a letter from the appropriate agency confirming dismissal of the charges.

PLEASE ANSWER THE FOLLOWING QUESTIONS:	**YES**	**NO**
1. Have you ever been denied the privilege of taking a pharmacy licensing examination? If yes, state which examination, where, and explain.	☐	☐
2. Have you ever had any disciplinary action taken against your pharmacist licence in any other jurisdiction? If yes, what jurisdiction and give date and explain.	☐	☐
3. Have you ever been physically or emotionally dependent upon the use of alcohol or drugs or treated by, consulted with, or been under the care of a professional for any substance abuse within the last two years? If yes, please provide a letter from the treating professional.	☐	☐
4. Do you have a physical disease, mental disorder, or any condition which could affect your performance or professional duties? If yes, provide a letter from your treating professional to include diagnosis, treatment, prognosis and fitness to practice.	☐	☐

Signature ____________________ Date ____________________

For information contact:
Bahamas Pharmacy Council
Johathan Forbes Building, Delancey Street
Phone: 326-0566
Email: bahamaspharmacycouncil@gmail.com
Website: pharmacycouncil.net

For Official use only

Officer: ____________________

Registration #: ____________________

Documents verifies by: ____________________