



**PHARMACY COUNCIL, GHANA**  
**APPLICATION FOR PHARMACY INTERNSHIP TRAINING**

Please affix a recent passport-sized photograph

1. Name.....  
(Surname) (Other names)

2. Date of Birth..... 3. Place of Birth.....  
(dd/mm/yyyy) (city/town, country)

4. Nationality.....

5. Permanent address

6. Contact address if different from 5

7. Tel. Res..... Tel. Cellular.....

8. E-mail address.....

9. Place of Residence in Ghana.....

10. Pharmacy Institution(s) attended.....

11. From..... to.....  
(mm / yyyy) (mm / yyyy)

12. Qualification and Date obtained.....  
(mm/yyyy)

13. List in Chronological order any vacation training you have undergone.

Institution	Job Description	From (mm/yyyy)	To (mm/yyyy)

**14. PHASE ONE INTERNSHIP PROGRAMME:**

**A. HOSPITAL / OTHER INSTITUTIONS**

Indicate in order of preference proposed region, district and institution for the internship

REGION	DISTRICT	PROPOSED INSTITUTION
	1 <sup>st</sup> choice	
	2 <sup>nd</sup> choice	
	3 <sup>rd</sup> choice	

**B. COMMUNITY PHARMACY INTERNSHIP**

Indicate in order of preference proposed institutions for the internship

1<sup>ST</sup> Choice.....

2<sup>nd</sup> Choice.....

3<sup>rd</sup> Choice.....

NOTE: The Pharmacy Council cannot guarantee that all applicants for the internship will be posted to institutions of their first choice.

**BANK DETAILS: Bank.....Branch.....**

**Account No .....**

**Signature of applicant.....Date.....**

**15. Were you sponsored by any government institution or mission? If yes indicate the following;**

Name of Institution.....

Postal Address.....

Telephone Number.....

**PLEASE ATTACH CERTIFIED COPIES OF ACADEMIC CERTIFICATES.**

FOR OFFICIAL USE ONLY

Applicant posted to: Hospital  Other Institution

Name of Hospital:.....From.....To.....

Other Institution:.....From.....To.....

Community Pharmacy:.....From.....To.....

Signature of Officer.....