

PHARMACY COUNCIL OF JAMAICA

MINISTRY OF HEALTH

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PHARMACIST'S POST-EVENT CONTINUING EDUCATION (C.E.) ACCREDITATION **FORM**

NAME OF PHARMACIST:NAME OF PROVIDER:		REG. #
		DATE OF C.E. ACTIVITY:
JRATION OF C.E. A	CTIVITY:	
TOPIC(S)	PRESENTER(S)	INDICATE WHAT WAS <u>LEARNT</u> FROM THE ACTIVITY IN NO LESS THAN <u>100</u> WORDS
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ADD1110.	NAL INFORMATION	MAY BE ATTACHED TO THIS APPLICATION FORM
gnature of Pharma	cist:	
ite:	·	
By signing this	form the Pharmacist is	indicating that the informationentered thereon is true and correct
OARAMATAAAAA AA		ACY COUNCIL OF JAMAICA USE ONLY
		AWARDED NUMBER OF CREDITS AWARDED: ATE: SIGNATURE:
FCFIPT #•	: n	