Boards Management Office

(for office use only)

CERTIFICATE NO.: _ _ _ _ / _ _ _ _ _

REGISTRATION NO. B D P B _ _ _ _ _

Ministry of Health
Brunei Darussalam

FORM

Application for Retention on the Register of Pharmacists

Every registered pharmacist who desires to be retained on the register must apply **before 30th November** of the proceeding year

How to complete this application form

- Read and **complete all questions**
- Please fill in the mandatory field (*)
- Use a **blue** pen only
- Print clearly in **BLOCK LETTERS**
- Place X in **all** applicable boxes: ☒

Privacy and Confidentiality

- The Brunei Darussalam Pharmacy Board and BMO are committed to protecting personal information as private and confidential.

***SECTION A:** Personal details

Title:
MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ Other: ______

*Full name (as appear in Identity Card):

*NAME to appear on certificate:

Date and Country of Birth: _ _ - _ _ - _ _ _ _
Age: ____ year *Sex: Male ☐ Female ☐

Nationality: ______ Passport No: ______ Country of Issue: ______

*Brunei I/C No: ______ *Colour: Yellow ☐ Purple ☐ Green ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Race: ______ Religion: ______

***SECTION B:** Contact information

***What are your contact details?**

Provide your current contact details below and place an ☒ next to your preferred contact phone number

Office/Business hours ☐ Mobile ☐

After hours ☐ Mobile ☐

*Official Email: *Personal Email:

Fax no:

***What is your residential address?**
Residential address **cannot** be a PO Box.

Post Code

What is your mailing address?
Your mailing address is used for postal correspondence

Post Code

*SECTION C: Activity Status

***I am working…**

- [ ] Full Time
- [ ] Part Time
- [ ] Not Working — State reason:

*Employment Sector:
- [ ] Government
- [ ] Private

***Work Type:**

- [ ] Academic
- [ ] Primary Health Care
- [ ] Administration
- [ ] Procurement/Distribution
- [ ] Consultancy
- [ ] Regulatory Affairs/Compliance
- [ ] Health Information Services
- [ ] Research
- [ ] Hospital
- [ ] Retail/Wholesale
- [ ] Locum
- [ ] Medical/Dental Clinic
- [ ] Industry *(please specify)*
- [ ] Other pharmaceutical field *(please specify)*
- [ ] Non-pharmaceutical field *(please specify)*

*SECTION D: Place of Practice

***Where is your place of practice?**

Name of Organisation

Department / Unit

Full address

Postcode

Country

Office Telephone no:

Mobile:

Fax:

Designation:

Date of registration:

*SECTION E: Declaration and Signature

I desire that my name be retained on the Register of Pharmacists for the year ________________________. I hereby declare that I am the person registered as above.

Signature of applicant:

Date: __ __ - __ __ - __ __ __ __

SECTION F: Checklist for submission of application for retention of registration

No.		Attached
1	Form filled in completely and signed by applicant	☐
2	Attached certificate:	☐
2.i	Copy of the previous annual certificate	☐
2.ii	Valid Pharmacy Registration Certificate from Pharmacist Registration Authority^	☐
2.iii	Valid Retention of Pharmacy Registration documents from other recognized Board/Authority^	☐
3	Two (2) passport size colour photos (with name written at the back)	☐
Note:	*^All original documents must be presented to and verified by the BDPB secretariat before the application is send to the Registrar.*	
Payment (Please bring exact amount for payment)		
i.	Retention of Registration Fee of B$100.00 (cash) (upon approval of application)	☐

Please hand in this form with required attachment to:	For further enquiry, you may contact:
Secretariat **BOARDS MANAGEMENT OFFICE** **2nd Floor, Ministry of Health** **Commonwealth Drive** **Brunei Darussalam** ☎ +673 2380170 Fax : +673 2382032	**BRUNEI DARUSSALAM PHARMACY BOARD** **Pharmaceutical Services** **Spg. 433, Rimba Highway, Kg. Madaras, Mukim Gadong 'A'** **Brunei Darussalam** ☎ +673 2393298 / 2393301 / 2393230 ext. 226/218 Fax: +673 2393297

SECTION G: *FOR OFFICE USE ONLY*

Complete: Yes ☐ No ☐ return to Applicant Date: __ __ - __ __ - __ __ __ __

Paid: ☐ Yes ☐ No ☐ Exempted

Verified by:

Signature:

Date: __ __ - __ __ - __ __ __ __

Revalidate by (Name of Officer):

Comments:

Signature:

Date: __ __ - __ __ - __ __ __ __

ENDORSED BY:
CHAIRPERSON OF BRUNEI DARUSSALAM PHARMACY BOARD

Signature:

Date: __ __ - __ __ - __ __ __ __

Comments:

☐ Approved for retention

☐ Collect fees and Issue registration certificate after payment made

☐ Reject the application

☐ Others (please specify):

Payment for Registration

Amount: **BND $100.00** Receipt No.:

Date: __ __ / __ __ / __ __ __ __