



EXPRESSION OF INTEREST FORM MEDICINE USE REVIEW TRAINING COURSE

Name: _____

Pharmacy Name and Address: _____

Email Address: _____

PSNZ Mem No: _____ Telephone (wk): _____

Location: (Please indicate where you are based including town/city and DHB)

.....

Date: (Please indicate date/day preferred*).....

*Workshop Time: 9 am until 5 pm (lunch included)

FEE: **\$535** (includes Pre-course Study Pack, Day Workshop and Assessment)

Please send forms to: NZ College of Pharmacists, PO Box 11 640, Wellington 6142
Tel: 04 802 0030 Fax: 04 381 4786 Email: nzcp@psnz.org.nz

Please comment on your local situation with respect to your DHB funding the service, with timeframes if possible:
