



Application for Approval as a Preceptor

Please complete and email to evolve@psnz.org.nz

All information provided will be kept strictly confidential.

Date of Application: _____

Preceptor Name: _____

Council Registration Number and Date of Registration as a Pharmacist in New Zealand:

Pharmacy Name: _____

Address: _____

Contact Phone: _____

Email: _____

Full Name of Intern you intend to train (if known):

Preceptors must have three years post registration experience as required by the Pharmacy Council under the Intern Training Programme Policy.

Are you currently training a pharmacy technician or another intern?

Yes No

I declare that:

- I will be working with my intern a minimum of three days a week, 8 hours each day.

- Have you, in the last five years, been the subject of any complaints made about your professional practice to the Health and Disability Commissioner or the Pharmacy Council of New Zealand? Yes No

- In the last five years have you been the subject of **disciplinary action** by the Pharmacy Council of New Zealand or the Health Practitioners Disciplinary Tribunal? Yes No

- Are you currently under any **competence review order** by the Pharmacy Council? Yes No

- Do you have any **current conditions on your Annual Practising Certificate** issued by the Pharmacy Council? Yes No

If you answered YES to any of the above, please put details on a separate sheet marked “Confidential to the Manager of the EVOLVE Intern Programme”.

I consent to PSNZ obtaining information about me from HDC and the Pharmacy Council of NZ regarding matters of discipline and complaints:

Signed: _____

Thank you for your application.

<i>Office Use Only</i>	
Date Approved: _____	Training Date: _____
Database Updated <input type="checkbox"/>	Letter Sent <input type="checkbox"/> HWFNZ Updated <input type="checkbox"/>
Next Approval Due: _____	