EXPRESSION OF INTEREST FORM

COMMUNITY PHARMACY ANTICOAGULATION MANAGEMENT SERVICE (CPAMS) TRAINING PROGRAMME

Name: _____

Pharmacy Name and Address: _____

_____

_____

Email Address: _____

Telephone (wk): _____

PSNZ Mem No: _____PCNZ No: _____

Contracted Pharmacy and Location: (Please indicate where you are based; include town/city & DHB)

_____

Does this pharmacy have a new CPAMS contract with your DHB: Yes/No

FEE: $345.00 (GST inclusive)

Please send forms to:
Pharmaceutical Society – College
PO Box 11640, Manners Street, Wellington 6142
Tel: 04 802 0030 Fax: 04 381 4786 Email: college@psnz.org.nz

Comments: _____

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