CLIENT REGISTRATION FORM

Please complete and return to PO Box 8181, Croydon VIC 3136 or admin@pharmatemp.com.au

Pharmacy Name:		
Pharmacy Address:		
		Post Code:

Contact Numbers:	Phone:	
	Mobile:	Email:

Contact Person:		Position:	

Dispensary Computer System:			
Average Number of Scripts Per Day:		Dispensary Technician?	Yes/No
POS Computer System:			
Number of Shop Staff:	Pharmacists:	Full Time:	Part Time:
Pharmacy Opening Hours:			
Hours Required to be worked by Pharmacist:			

Would you like to register for a permanent position?	Yes/No

If so, please provide details (i.e. hours, incentives, etc.) that will make your position appealing to potential applications:-

Are you responsible for a methadone programme?	Yes/No
Are you responsible for a nursing home or other special care facility?	Yes/No

Please specify any other particular requirements associated with the pharmacist's duties:-

Completion of this registration form indicates acceptance of all terms and conditions as outlined on the attached contract and fee schedule. Any changes to the fee structure will be notified in writing.

Signature of Authorised Person:	Position:
Witnessed By:	Position:
Date:	