

PHARMACIST REGISTRATION FORM

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

- Please supply a current resume outlining your work experience -

Name:	
Address:	
	Post Code:

Phone:	Business:	Home:	Mobile:
Email:			

Date of Birth:		Male / Female
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Year of Registration:		Pharmacy Board Registration No:	
Do you have an ABN:	Yes/No	Tax File No:	

Dispensary Computer Systems with which you are competent:	
POS Computer Systems with which you are competent:	

Please list three pharmacy referees:

Name:		Contact No:	
Name:		Contact No:	
Name:		Contact No:	

Are you interested in a permanent position?	Yes/No
Are you prepared to work in weekly blocks?	Yes/No
Do you have your own car?	Yes/No
Are you prepared to travel to rural areas?	Yes/No

Please supply details of work availability – days and hours:-

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	