Practitioner Details

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<tr>
<th>Monitoring &amp; Compliance number</th>
<th>Name (Last, First)</th>
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Practitioner’s Declaration

By signing this form I acknowledge and confirm that I am aware that:

a. I must always practise as a pharmacist in the presence of another supervising pharmacist

b. only hours undertaken in accordance with the Supervised practice arrangement approved by the Board may be counted towards supervised practice hours required in condition 1(b) on my registration

c. at the completion of the requisite supervised practice hours I must provide evidence of successful completion of these hours in a format specified by the Board

d. all CPD must be undertaken in accordance with the Board’s Registration Standard: Continuing professional development

e. the CPD plan referred to condition 1(c) on my registration must be updated to include the following information for each activity undertaken:
   
   I. start and finish date of activity
   II. source or provider
   III. type of activity
   IV. topics covered during activity
   V. accreditation status
   VI. CPD activity group
   VII. number of Board CPD credits assigned
   VIII. how the activity will impact on my practice, and

f. the examination(s) requirement for condition 1(e) on my registration must be undertaken in accordance with the Board’s Registration Standard: Examinations for Eligibility for General Registration.

Signature __________________________ Date __________

Return form to

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<tr>
<th>Case officer</th>
<th>Email</th>
<th>Post</th>
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