CTF-011

PHARMACISTS COUNCIL OF ZIMBABWE

REPORT ON COMPLETION OF TWELVE MONTHS FOR PHARMACY TECHNICIANS RESTRICTED IN DESIGNATED HEALTH INSTITUTIONS/STATE INSTITUTIONS

NAME OF TRAINEE :……………………………………………………………………

NAME OF THE INSTITUTION, FIRM OR PREMISES ………………………………..
………………………………………………………………………………………………

NAME OF SUPERVISOR…………………………………………………………………..

DATE COMMENCED………………………………………………….

DATE COMPLETED:……………………………………………………………………….

DATE OF ANNUAL/CASUAL LEAVE:…………………………………………………

SICK LEAVE:……………………………………………………………………………..

SECTION 2

Comment below on the type of activities;
Undertaken during the period.

Give where possible periods spent and the volume of work performed.

SECTION 3

Details any visits or attachments in any other branch or pharmacy or other institutions.

SECTION 4

Indicate aptitude and enthusiasim, also comment on any involvement in meetings, symposia, seminars, lectures, talks etc.

SECTION 5

Please provide general comments and your appraisal of the trainee.

SECTION 6

RECOMMENDATIONS:

SIGNED (SUPERVISOR) ………………………………….. DATE…………………