



**PHARMACISTS' COUNCIL ZIMBABWE**

2 Cork Road. Belgravia Harare, Telephone: 740074/740158/741302/0772137039  
P.O BOX CY 2138, Causeway, Harare. Email Address: [admin@pcz.co.zw](mailto:admin@pcz.co.zw)

**RENEWAL OF A PRACTISING CERTIFICATE: PHARMACY TECHNICIAN  
2020**

**(a) Renewal of Practising Certificate for the period January to December 2020:**

**Total Amount Due**

**z\$ 759.00** (including VAT)

**PCZ Account Number: CBZ KWAME NKURUMAH: ACC.NO. 011 213 124 500 19**

Your Practising Certificate authorising you to practise as a **Pharmacy technician** expires on **31 December 2019**. If you wish to continue to practise after this date, **complete and return** this form with the appropriate fees as soon as possible before **31 January 2020**. You are required to complete all sections on the form to enable Council to update its records.

**REGISTRATION NUMBER:**

**FULL NAME:**

Failure to pay the full amount by the due date will attract late payment penalties.

**NOTE: PROOF OF ATTENDING CONTINUING PROFESSIONAL DEVELOPMENT (CPD) PROGRAMMES MUST BE ATTACHED TO THIS FORM.**

*It is an offence to practise whilst not in possession of a valid Practising Certificate and failing to advise Council of any change in your registration particulars.*

**P.T.O**

*TO BE COMPLETED BY ALL APPLICANTS*

**PRACTITIONER INFORMATION UPDATE FORM (Kindly Print)**

**1. First Name.....2. Middle Name.....**

**3. Maiden Name.....4. Surname.....**

**5. Gender.....6. Marital Status.....**

**7. Date of Birth.....8. Place of Birth.....**

**9. National ID Number.....10. PCZ Number.....**

**11. Profession .....**

**12. Qualification(s) [include awarding institution(s) and year of award]**

**(a).....**

**(b).....**

**(c).....**

**(d).....**

**(e).....**

**13. Residential Address.....**

**14. Postal Address .....**

**15. Email Address.....**

**16. Cellphone Number(s) .....**

**17. Current Employer.....Date of Commencement.....**

**18. Institution Employed and Physical Address**

.....

**19. Business telephone number .....**

**20. Employment Status: Full Time.....Part Time.....Temporary.....**

**21. Area of Employment: Government.....Mission....Local Authority.... Private....**

**22. Type of Institution**

**Hospital.....Academic.....Retail Pharmacy.....Regulatory.....Industry.....**

**Private Practice (Optometry/Dispensing Optician).....Other (Specify).....**

**23. Province Employed.....24. District.....**

**25. Town Employed.....**

**26. Current Studies.....**

**PLEASE ENSURE THAT ALL THE SECTIONS ABOVE ARE COMPLETED.**