



SINGAPORE PHARMACY COUNCIL

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ASSESSMENT FORM FOR PHARMACISTS ON CONDITIONAL REGISTRATION

Name of Pharmacist: _____ Year of Assessment: 1 2 (circle one)

Organisation: _____ Work Location: _____

Period of Assessment: _____ to _____ Assessment No: 1 2 3 4 (circle one)
(DD/MM/YYYY) (DD/MM/YYYY)

Before you complete this Assessment Form for the pharmacist, please take note of the following:

1. Every section of the form must be completed. The completed form must be returned to Singapore Pharmacy Council under confidential cover in a sealed envelope addressed to the Registrar, Singapore Pharmacy Council, College of Medicine Building, 16 College Road, Singapore 169854.
2. The Assessor's duty is to provide an accurate and objective assessment of the registered pharmacist by selecting the appropriate grade with a "√".
3. The Assessor has the duty to report to the Singapore Pharmacy Council immediately if the pharmacist under assessment is assessed to be unsafe to continue practice as a pharmacist.
4. You are encouraged to write at least 1 – 2 points on the performance of the candidate to justify the grade given. For "Outstanding" and "Unsatisfactory" grades, the reason(s) for the selection **must** be stated.

I. ASSESSMENT OF PHARMACIST

1. PROFESSIONAL EXPERTISE

Pharmacist demonstrates the ability to apply his/her pharmaceutical knowledge in the course of duty, e.g. drug information, legal requirements, dispensing skills, drug distribution, etc

Unsatisfactory	Meet Requirements	Exceed Requirements	Outstanding

State reason(s) for the selection _____

2. ETHICAL BEHAVIOUR IN PHARMACY PRACTICE

Pharmacist demonstrates a high standard of ethical behaviour within the pharmacy practice. Examples are professional integrity, patient confidentiality and good professional conduct.

Unsatisfactory	Meet Requirements	Exceed Requirements	Outstanding

State reason(s) for the selection _____

II. RECOMMENDATION TO SINGAPORE PHARMACY COUNCIL:

(Part II is to be filled at the end of the assessment period.)

Name of Conditionally Registered Pharmacist: _____

Full Period of Assessment: _____ to _____
(DD/MM/YYYY) (DD/MM/YYYY)

The pharmacist is **suitable*** to be registered under Full Registration Yes No

*Note: The pharmacist must apply for full registration. It is not automatically given to him / her.

I confirm that during the period of this report, the above mentioned pharmacist:

- i. has / has not* had any complaints against him / her from patients and / or colleagues
- ii. has / has not* been responsible for any procedural errors or adverse outcomes
- iii. has / has not* faced any disciplinary action.
- iv. has / has not* been able to perform the duties of a pharmacist satisfactorily.

The details are as follows (if applicable):

* - delete accordingly

Name of Supervisor: _____ Designation: _____

Signature of Supervisor: _____ Date: _____

Organisation: _____

Name of Pharmacy Manager: _____

Signature of Pharmacy Manager: _____ Date : _____

FOR OFFICE USE:

Recommendation for Full Registration: Yes No

Processed by
Signature and Name Designation Date

Approved by
Signature and Name Designation Date