

# PSI – IRL3 – HEALTH DECLARATION FORM



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## MEDICAL REPORT (For the purposes of registration as a pharmacist)

### DECLARATION BY APPLICANT

(to be signed by the applicant in the presence of the registered medical practitioner)

I, the undersigned, wish to undergo a medical examination for the purposes of obtaining registration as a pharmacist, which may include taking sole charge of a community or hospital pharmacy

Name of Applicant \_\_\_\_\_  
(Name in full as it appears on the Birth / Marriage Certificate)

Of \_\_\_\_\_  
(Address of Applicant)

\_\_\_\_\_  
(Address of Applicant continued)

Date of Birth \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of Applicant)

### MEDICAL CERTIFICATE

To: The Registrar, Pharmaceutical Society of Ireland, 18 Shrewsbury Road, Ballsbridge, Dublin 4, Ireland

I, THE UNDERSIGNED REGISTERED MEDICAL PRACTITIONER, HEREBY CERTIFY THAT:-

- the applicant has signed the above declaration in my presence
- I have examined the applicant with regard to his/her physical or mental health

My opinion as to the state of the applicant's physical or mental health is as follows:-

The examination **did not** disclose any reason on grounds of physical or mental health why he/she should not be able to discharge the responsibilities of a registered pharmacist.

Yes  No

If **No** – state reasons below-

\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of Medical Practitioner)

Print Name: \_\_\_\_\_

Registration Number: \_\_\_\_\_

Practice Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: \_\_\_\_\_

Official Surgery Stamp
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