

## CHANGE OF SUPERVISING/SUPERINTENDENT PHARMACIST Fee Form

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Full Name and Address of Retail Pharmacy Business: \_\_\_\_\_  
\_\_\_\_\_

I wish to pay the amount of **€85.00** by one of the following options:

**A) By Attaching:** Postal Order  Bank Draft  Cheque

(Please make your Postal Order/Bank Draft/Cheque payable to **THE PHARMACEUTICAL SOCIETY OF IRELAND**)

**OR**

**B) By** Visa  Mastercard  Laser

Card Number \_\_\_\_\_ Expiry Date \_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_

Security Code \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_  
(Please sign)

For office use: Amount \_\_\_\_\_ Date \_\_\_\_\_

Please return to:

**Registration Unit,  
The Pharmaceutical Society of Ireland,  
18 Shrewsbury Road,  
Dublin 4  
IRELAND**

Phone: (01) 2184000

Fax: (01) 2837678

E-mail: [rpbreg@pharmaceuticalsociety.ie](mailto:rpbreg@pharmaceuticalsociety.ie)

Website: [www.pharmaceuticalsociety.ie](http://www.pharmaceuticalsociety.ie)