

APPLICATION FOR RESTORATION
Pharmacist Returning to Practice

CONTACT INFORMATION

1.

☐ Ms ☐ Mrs ☐ Miss ☐ Mr ☐ Dr

Legal Name

(Name of Applicant in full as on Birth Certificate / Passport or other authorising document where appropriate)

Address

_____ Registration No: _____

_____ Phone Number: _____

City Country

Mobile Number: _____

Email Address: _____

Please
attach
one
photograph
here

CURRENT STATUS

2.

- Not registered less than 6 months ☐
- Not registered 6 months to 1 year ☐
- Not registered 1 year to 3 years ☐
- Not registered more than 3 years ☐

REASON FOR CANCELLATION OF NAME FROM REGISTER

3.

- (a) Maternity leave/paternity leave/parental leave/carer's leave ☐
- (b) Relocation *(if practising as a pharmacist elsewhere please complete Section 4 below)* ☐
- (c) Career break ☐
- (d) Non payment of fees *(restoration request can only be considered if request to be restored is received within six months of the due date of payment of the annual fee)* ☐
- (e) Retirement ☐
- (f) Fitness to practice *(if yes here, please complete page 11)* ☐
- (g) Other *(Please specify _____)* ☐

OTHER INFORMATION

4. Have you been practising or operating a pharmacy in another jurisdiction?

Yes ☐

No ☐

If you have answered 'Yes', please give details.

Name of body														
Registration No.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please enter date first registered and date discontinued	Date first registered	d	d	m	m	y	y	Date discontinued	d	d	m	m	y	y

REGISTRATION WITH OTHER HEALTH REGULATORY AND/OR SOCIAL CARE BODIES

5. Are you currently or have you previously been registered with any other health regulatory and/or social care bodies in any country (examples includes Medical Council, CORU, ...)?

Yes ☐

No ☐

If you have answered 'Yes' to question 5, please give details.

Name of body														
Registration No.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please enter date first registered and date discontinued (if applicable)	Date first registered	d	d	m	m	y	y	Date discontinued (if applicable)	d	d	m	m	y	y

Name of body														
Registration No.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please enter date first registered and date discontinued (if applicable)	Date first registered	d	d	m	m	y	y	Date discontinued (if applicable)	d	d	m	m	y	y

Name of body														
Registration No.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please enter date first registered and date discontinued (if applicable)	Date first registered	d	d	m	m	y	y	Date discontinued (if applicable)	d	d	m	m	y	y

Name of body														
Registration No.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Please enter date first registered and date discontinued (if applicable)	Date first registered	d	d	m	m	y	y	Date discontinued (if applicable)	d	d	m	m	y	y

Name of body										
Registration No.										

Please enter date first registered and date discontinued (if applicable)	Date first registered	d	d	m	m	y	y	Date discontinued (if applicable)	d	d	m	m	y	y

RESTORATION PROCESS (Not registered in the Register of Pharmacist for a period of less than 6 months)

6. **Please complete** (Outline the pharmacy roles, if any, carried out by you in Ireland and/or any other jurisdiction, from first registration and during the period of removal from the Register of Pharmacists in Ireland, together with the details of any other professional experience)

Details of professional activity and practice since acquiring entitlement to practise independently *

** this relates to periods of practice since acquiring the entitlement to practise as a pharmacist in an independent and unsupervised capacity*

Date Started:	Date Finished:	Name & Address of Premises:	Area of Practice: (community, hospital, industry, academic)	Job Title	Average No. of hours worked per week:

The following documents to be submitted:-

- Certificate of current professional status (with which the applicant is registered in any other jurisdiction at time of applying for restoration or has been registered during the intervening period in any other jurisdiction(s))
- Criminal clearance certificate or Statutory Declaration Confirming Professional Status form (if not registered or practising as a pharmacist during the period of cancellation from the Register)
- Fee

In addition the applicant is required to:-

- Provide confirmation of on-going CPD since cancellation from PSI Register

RESTORATION PROCESS *(Not registered in the Register of Pharmacist for a period 6 months to 1 year)*

7. **Please complete** (Outline the pharmacy roles, if any, carried out by you in Ireland and/or any other jurisdiction, from first registration and during the period of removal from the Register of Pharmacists in Ireland, together with the details of any other professional experience)

Details of professional activity and practice since acquiring entitlement to practise independently *

** this relates to periods of practice since acquiring the entitlement to practise as a pharmacist in an independent and unsupervised capacity*

Date Started:	Date Finished:	Name & Address of Premises:	Area of Practice: (community, hospital, industry, academic)	Job Title	Average No. of hours worked per week:

The following documents to be submitted:-

- Certificate of current professional status (with which the applicant is registered in any other jurisdiction at time of applying for restoration or has been registered during the intervening period in any other jurisdiction(s))
- Criminal clearance certificate or Statutory Declaration Confirming Professional Status form (if not registered or practising as a pharmacist during the period of cancellation from the Register)
- Fee

In addition the applicant is required to:-

- Provide confirmation of on-going CPD since cancellation from PSI Register
- Undertake to complete a self-assessment against the PSI's Core Competency Framework to assess competency and learning needs. An assessment template will be provided by the PSI

RESTORATION PROCESS *(Not registered in the Register of Pharmacists for a period 1 year to 3 years)*

8. **Please complete** (Outline the pharmacy roles, if any, carried out by you in Ireland and/or any other jurisdiction, from first registration and during the period of removal from the Register of Pharmacists in Ireland, together with the details of any other professional experience)

Details of professional activity and practice since acquiring entitlement to practise independently *

** this relates to periods of practice since acquiring the entitlement to practise as a pharmacist in an independent and unsupervised capacity*

Date Started:	Date Finished:	Name & Address of Premises:	Area of Practice: (community, hospital, industry, academic)	Job Title	Average No. of hours worked per week:

The following documents to be submitted:-

- Certificate of current professional status (with which the applicant is registered in any other jurisdiction at time of applying for restoration or has been registered during the intervening period in any other jurisdiction(s))
- Criminal clearance certificate or Statutory Declaration Confirming Professional Status form (if not registered or practising as a pharmacist during the period of cancellation from the Register)
- Fee

In addition the applicant is required to:-

- Provide confirmation of on-going CPD since cancellation from PSI Register
- Undertake to complete a self-assessment against the PSI's Core Competency Framework to assess competency and learning needs. An assessment template will be provided by the PSI.
- Undertake a period of practical training of not less than 2 weeks if the applicant has not practised in another jurisdiction during the period of cancellation from the Register in Ireland. Exemption from this requirement may be obtained solely upon the production of satisfactory evidence that direct patient care pharmacy practice has been engaged in by the applicant in another jurisdiction.

• **RESTORATION PROCESS** (*Not registered in the Register of Pharmacist for more than 3 years*)

9. **Please complete** (Outline the pharmacy roles, if any carried out in Ireland and/or any other jurisdiction, from first registration and during the period of removal from the Register of Pharmacists in Ireland together with the details of any other professional experience)

Details of professional activity and practice since acquiring entitlement to practise pharmacy independently *

**this relates to periods of practice since acquiring the entitlement to practise as a pharmacist in an independent and unsupervised capacity*

Date Started:	Date Finished:	Name & Address of Premises:	Area of Practice: (community, hospital, industry, academic)	Job Title	Average No. of hours worked per week:

The following documents to be submitted:-

- Certificate of current professional status (with which the applicant is registered at time of applying for restoration or has been registered during the intervening period in any other jurisdiction(s))
- Criminal clearance certificate or Statutory Declaration Confirming Professional Status form (if not registered or practising as a pharmacist during the period of cancellation from the Register)
- Fee

In addition the applicant is required to:-

- Provide confirmation of on-going CPD since cancellation from PSI Register
- Undertake to complete a self-assessment against the Core Competency framework to assess competency and learning needs.
- Undertake a period of practical training of not less than 4 weeks if the applicant has not practised in another jurisdiction during the period of cancellation from the Register in Ireland. Exemption from this requirement may be obtained solely upon the production of satisfactory evidence that direct patient care pharmacy practice has been engaged in by the applicant in another jurisdiction.

ABILITY TO COMMUNICATE IN THE ENGLISH OR IRISH LANGUAGE (S)

10. Please note that both the Irish and English languages are an official language of the Republic of Ireland. Applicants for registration should be able to communicate in either English **OR** Irish

Do you acknowledge that, when practising in Ireland, you will be required to perform the professional duties of a pharmacist through the English [**or** Irish] language(s)? Yes ☐ No ☐

Do you acknowledge that it is essential, for the purposes of patient safety, that you are able to communicate effectively through the English [**or** Irish] language(s) with patients, health professionals and others and that they are able to understand fully the advice and information that you provide? Yes ☐ No ☐

Do you consider that you have a sufficient level of competence in the English [**or** Irish] language(s) to practise pharmacy safely, communicate effectively with patients, health professionals and others in the English **or** Irish language(s), and discharge in full the professional responsibilities of a registered pharmacist and in this context to ensure that patients are at all times protected? Yes ☐ No ☐

HEALTH DECLARATION

11.

- 11.1 Do you have any problems with your physical or mental health that may impair your ability to practise?

Yes ☐

No ☐

- 11.2 If you have answered 'yes' to 11.1 please provide details on a separate sheet.

PERSONAL CHARACTER/REPUTATION & PROFESSIONAL STANDING

12.

Personal Character & Reputation

Are you or have you ever been convicted of a criminal offence in any country / state / region? Yes ☐ No ☐

If Yes, please complete the following:

Name of Country/ State / Region	Nature of Offence	Penalty/Sanction imposed

Professional Character & Standing as a Pharmacist / Entitlement to Operate a Pharmacy

Are you or have you ever been sanctioned, restricted or prohibited, in connection with practising as a pharmacist and/or operating a pharmacy in any country / state / region? Yes ☐ No ☐

If Yes, please complete the following:

Name of Country/ State / Region	Circumstances of the sanction connected with your practise as a pharmacist and/or entitlement to operate a pharmacy	Penalty/Sanction imposed

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Professional Character & Standing in the provision of Health/Social Care Services

Are you or have you ever been qualified/entitled/registered to practise or carry on any other practice, profession or occupation which consists of the provision of health care or social care services? Yes ☐ No ☐

If Yes, please state the following:

Name & title of the practice, profession or occupation	Country(ies) where practice, profession or occupation was/is being carried on

Are you or have you ever been sanctioned, restricted or prohibited from practising or carrying on, any other practice, profession or occupation which consists of the provision of health care or social care services? Yes ☐ No ☐

If Yes, please complete the following:

Name of Country/ State / Region	Circumstances of the sanction connected with the practise or carrying on of any practice, profession or occupation which consists of the provision of health care or social care services?	Penalty/Sanction imposed

Signature		Date							

DECLARATIONS BY APPLICANT (To be completed by the applicant)

13.

I DO SOLEMNLY DECLARE THAT:

- (a) I have no problems with my physical or mental health that may impair my ability to practise about which I have not advised the Registrar.
- (b) I have not been prohibited from practising as a pharmacist or operating a pharmacy in any country.
- (c) I undertake to complete the Core Competency framework self-assessment, and/or undertake appropriate mentored practical training in line with Council policy prior to returning to independent patient facing practice.
- (d) I have not been prohibited from practising any profession or occupation which mainly consists of the provision of health or social care services in Ireland or any country.
- (e) I have not been convicted of any offence under Irish law or under the law of any other country which might reasonably be considered to have a bearing on my fitness to be registered to practise as a pharmacist in Ireland.
- (f) I am not aware of any deficiencies in my character, reputation or record of my professional conduct in Ireland or any other country, within the meaning of Directive 2005/36/EC as amended or the Pharmacy Act 2007 as amended.
- (g) The information I give in this form and in any supporting documents is full and accurate.
- (h) I understand that, if I am found to have given false or misleading information, I may be subject to Fitness to Practise proceedings under Part 6 of the Act.

Signature

	Date		
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I CONSENT TO:

The PSI processing data about me for the purpose of complying with its statutory duties in respect of public protection and ensuring that its registrants are fit to practise and to supply other competent authorities with such information as the PSI deems appropriate in the carrying out of its statutory duties.

Signature

	Date		
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PAYMENT OF APPLICATION FEE

14.

Please complete the section(s) below, and enclose the relevant fee with your application.

- Fee for Restoration of Registration as a Pharmacist after voluntary cancellation: €540.00
- Fee for Restoration of Registration as a Pharmacist after removal for non-payment of fees: €710.00
(Such application to be made within 6 months of when the fee became due)

Applicant's Full Name	
PSI Registration Number	
Payment Method (please tick as appropriate)	<ul style="list-style-type: none"> • Postal Order/Bank Draft/Cheque (please attach) <i>Made payable to The Pharmaceutical Society of Ireland</i> <input type="checkbox"/> • Credit/Debit Card (complete section below) <input type="checkbox"/>

Card Payment Details		
Card Type	Visa <input type="checkbox"/>	MasterCard <input type="checkbox"/>
Cardholder Name		
Card Number		
Expiry Date		
Security Code		
<p>I authorise the PSI to charge the above card with the following amount (please tick):</p> <div style="text-align: center; margin-top: 20px;"> €540 <input type="checkbox"/> €710 <input type="checkbox"/> </div> <div style="margin-top: 40px;"> Signature of Cardholder: _____ Date: _____ </div>		

**APPLICATION FOR RESTORATION
Pharmacist Returning to Practice**

Complete this Section only if you have answered Yes to 3 (f) on page 1

CRIMINAL OFFENCE CONVICTION

Provide details of:-

- 1) Criminal offence committed

- 2) Date when offence was committed

- 3) Details of penalty imposed

- 4) Extenuating circumstances you wish to be taken into account for your application

DISCIPLINARY ACTION

If applicable, provide details of:-

- 1) Disciplinary action taken against you

- 2) Date when disciplinary action was taken

- 3) Outcome of the disciplinary action taken against you including details of penalty imposed

4) Extenuating circumstances you wish to be taken into account for your application



☐

I certify that the above information is correct

Date

Applicant signature