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**Application to become a Full / Credentialed Member of the College of Mental Health Pharmacy**

This information will be treated as STRICTLY CONFIDENTIAL

## Personal Details

## Mr / Ms / Mrs / Dr / Other:

## Name:

## Addresses

Home address:

Home telephone:

Home e-mail:

Work address:

Work telephone:

Work e-mail:

Preferred mailing address (please delete as applicable): Home / Business

#### Professional qualifications

Year of qualification:

Professional body name:

Membership number:

CMHP membership username:

(Your username is unique to you and will enable us to verify your membership. It can be found by logging into the CMHP website and viewing your profile.)

Other professional body memberships if applicable:

#### Academic qualifications

Please give details of your qualifications (Degrees, diplomas etc.) with the name of the institution that awarded them and the date of the award. In particular provide details of qualifications in psychiatric pharmacy

**Professional Work Experience**

Please give details of your work experience in pharmacy with names of employer, period of employment and job title. In particular highlight those jobs that involved psychiatric pharmacy practice.

|  |  |  |
| --- | --- | --- |
| Date | Employer | Job Title |
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**Please indicate if you would prefer an online (“virtual”) or in person Viva (**in person will only be able to take place in October at the Annual CMHP conference)

|  |  |
| --- | --- |
|  | Preference  |
| Online |  |
| Virtual |  |

**References**

Please provide the names, addresses and telephone numbers of two pharmacists who support your application to become a member of the College of Mental Health Pharmacy. These referees will be contacted on submission of your application form.

|  |  |  |
| --- | --- | --- |
|  | Referee one | Referee two |
| Title |  |  |
| Name |  |  |
| Address |  |  |
| Email |  |  |
| Telephone |  |  |

**Notification of successful outcome**

If you are successful in your credentialing, it is the intention for the College to write to senior members of your employment organisation. Please state below whom you would like the Registrar to write to (this would usually be your chief pharmacist and trust chief executive).

Name:

Position/Job title:

Address:

Email address:

Name:

Position/Job title:

Address:

Email address:

Date of completion:

I confirm that I understand the credentialing fee of £300 is payable at the time of application and not refundable except at the discretion of the registrar/council who may give consideration to extenuating circumstances if applicable. Further details are available on the CMHP website or at registrar@cmhp.org.uk

Signature: Date: