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| **Index Number:** |
| **Date Received:** |

**APPLICATION FOR ACCREDITATION**

**AS A PROFESSIONAL TRAINING SITE**

*(For community pharmacies to host pharmacy students in their 2nd and 3rd academic year practices and pre-final exam internships)*

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| **DATA OF THE HIGHER EDUCATION INSTITUTION** | | |
| **Name of Institution:** Semmelweis University | | **Institutional ID:** FI62576 |
| **Faculty:**Faculty of Pharmaceutical Sciences | | |
| **Cím:** 1085 Budapest, Üllői út 26. | | |
| **Program:** Pharmacy | **Form of Training:** Full-time | **Language of Instruction:** Hungarian |

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| **DATA OF THE COMMUNITY PHARMACY** | |
| **Name:** | |
| **Address:** | |
| **Head Pharmacist:** | |
| **Number of Qualified Staff:**  **Pharmacists: \_\_\_\_ persons, of which specialist pharmacists: \_\_\_\_ persons**  **Pharmacy assistants: \_\_\_\_ persons, of which specialist assistants: \_\_\_\_ persons** | |
| **Pharmacy License Number:** | |
| **Phone:** | **E-mail:** |

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| **DATA OF THE PHARMACIST RESPONSIBLE FOR THE TRAINING**  (*A maximum of 3 students may be supervised by one responsible pharmacist at the same time)* | |
| **Name: Professional Registry Number:** | |
| **REQUIREMENT:**  **Specialization OR at least 3 years of professional experience in the pharmacy field** | |
| **Date of Specialization Exam** (dd/mm/yy): | **Number of Specializations:** |
| **Specialization Area(s):** | |
| **OR** | |
| **Work Experience: (years), from to**  **Workplace:** | |
| **Phone:** | **E-mail:** |

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| **CONDITIONS FOR ACCREDITATION AS A TRAINING SITE** | | | | |
| **Weekly opening hours reach 40 hours** | **YES** |  | **NO** |  |
| **Prescription volume (average)** | **prescriptions/month** | | | |
| **Magistral (compounded) medicine preparation** | **YES** |  | **NO** |  |
| **Aseptic medicine preparation** | **YES** |  | **NO** |  |
| **Administration and distribution of controlled substances** | **YES** |  | **NO** |  |
| **Sale of medical aids and infant/adult formulas** | **YES** |  | **NO** |  |
| **Pharmaceutical care activities** | **YES** |  | **NO** |  |
| **Access to professional databases for students** | **YES** |  | **NO** |  |
| **Availability of professional journals** | **YES** |  | **NO** |  |
| **Main characteristics of the pharmacy's quality assurance system:**  **ISO**  **Quality Manual** | **YES**  **YES** |  | **NO**  **NO** |  |

*\** *Please mark with an X.*

**DECLARATION**

**I hereby declare, under my own responsibility, that the information provided in this form is true and correct.\***

**Place and Date: ………………………………………......., dd/mm/yy .....................................…………..............................**

**Signature of pharmacist responsible for the training: ………………………………………………………………………**

**Signature of headpharmacist: ..............................................………………………………………………………………………**

**Official stamp**

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| **EVALUATION BY THE HIGHER EDUCATION INSTITUTION** | |
| **APPROVED** | **NOT APPROVED** |
| **Signature of Committee Chair:** | |
| **Date of Accreditation:** | |
| **Validity End Date of Accreditation:** | |

**The accreditation is valid for 3 years, provided there is no change in the data of the Community Pharmacy or the Training Pharmacist. In the event of changes, a new application must be submitted!**