



**HEALTH PROFESSIONS COUNCIL OF NAMIBIA**

**PHARMACY BOARD OF NAMIBIA**

**Confirmation of personal details**

Mr/Ms (full names) \_\_\_\_\_ (client # \_\_\_\_\_)

(profession) \_\_\_\_\_

Confirms the following details:

- Postal address \_\_\_\_\_
- Residential (home/street) address, village/town/city \_\_\_\_\_  
\_\_\_\_\_
- Name of Employer / Business / Practice \_\_\_\_\_  
\_\_\_\_\_
- Business address of Employer / Business (street name and number/shopping complex and town)  
\_\_\_\_\_  
\_\_\_\_\_
- Contact number:
  - at home \_\_\_\_\_
  - at work \_\_\_\_\_
  - cell phone \_\_\_\_\_
  - fax \_\_\_\_\_
  - e-mail address (*Please print clearly*) \_\_\_\_\_

Any relevant comments or information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I undertake to report any change in any of the above details to the relevant Council within 30 days**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**