



The Pharmaceutical Society of Namibia (PSN)  
in collaboration with  
The Health Science Academy (HSA)



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Training Course Application Form: SPEL for support personnel		
This course is presented by HSA in co-operation with the Pharmaceutical Society of Namibia (PSN)		
<b>Applicant's details</b>		
Surname		
Name		
Title (Mr/Mrs/Ms/Dr)		
Ethnic group (for statistical purposes)	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Highest qualifications		
Identity number		
Employer/pharmacy		
Current position/job title		
Name to be written on certificate		
Address for correspondence	Work:	Home:
Tel number	(h) ( )	(w)( )
Cell number	( )	
Personal e-mail address		
<b>Course – SPEL for support personnel</b>		
Application for module name/s		
Experience in this field?	1 year or less	1-3 years 3 years or more
<b>Please indicate who should be invoiced:</b>		
<b>Course fee: N\$300.00 per module electronic version or N\$ 1300.00 per pillar of modules</b>		
<b>Payment details</b>		
Direct deposit/EFT <input type="checkbox"/> (POP attached)		
Pharmaceutical Society of Namibia	Bank	Nedbank Namibia
	Branch code	461 038
	Account name	Pharmaceutical Society of Namibia (PSN)
	Account number	11010000906

The PSN-HSA partnership reserves the right to make changes without prior notification

I hereby apply to be enrolled in the abovementioned course. I understand that:

- The fees include the assessment fee for the course SPEL for support personnel
- The fees are not refundable
- If I do not attempt an assessment for any reason within the allotted time period other than sickness (supported by a doctors' certificate), I will not be eligible for a refund of any part of the fee. Furthermore, should I not be competent when assessed at the first attempt, further assessment fees will be for my own account.

I agree to the above terms and conditions governing my application and I agree to be bound by them.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

		DATE	SIGNATURE
1. Date application received			
2. Documents attached	HPCNA Application form		
	ID		
3. Receipt acknowledged			
4. Invoice sent			
5. Payment received			
6. Registration approved by PSN			
7. Registration sent to HSA			
8. Enrolment done by HSA			

**PLEASE TAKE NOTE THAT NO APPLICATION FORM WILL BE PROCESSED WITHOUT ALL THE NECESSARY DOCUMENTS OR WITH INCOMPLETE INFORMATION.**

**AGREEMENT**

I, the undersigned, ..... declare that this application constitutes a binding agreement upon the terms set out there in between myself and the PSN-HSA Partnership when signed. I understand that it is **my responsibility to notify PSN within 5 working days if there have been any changes in my personal information**, via email [edudesk@psn.com.na](mailto:edudesk@psn.com.na)

I also understand that the PSN-HSA Partnership will be under no obligation to issue any results if there are any amounts outstanding on my account.

Signature of applicant \_\_\_\_\_ Date: \_\_\_\_\_