



**IRISH
PHARMACY
UNION**

The voice of
community pharmacy

Application Form for Membership

1. Title _____ First name: _____ Surname: _____

2. Address: _____

Email _____ Tel No: _____

Mobile: _____ If you would like to receive SMS Text alerts please tick

3. PSI Registration No: _____ Year of Registration with PSI: _____

Year of Qualification (If different from Year of PSI Registration): _____

4. Please indicate your Category with an "X" in the appropriate box:

Community Proprietor

Community Employee

5. Name and Address of Employer: _____

How long have you been in this employment? _____

6. Are you, or have you been, a member of this or another Union? Yes No

If so, please give details: _____

7. Are you, or have you been, a member of the IPU Academy? Yes No

8. Name of Proposer for Membership (must be an IPU Member): _____

Signature of Proposer: _____

I hereby apply for membership of the Irish Pharmacy Union and agree to abide by the Articles of the IPU's Constitution and to act in accordance with resolutions passed at Annual General Meetings of the IPU and to obey directives from the Executive Committee. I understand that it may be necessary for the Executive Committee to seek additional information.

I certify that the answers and other details supplied above are true.

Signature of Applicant: _____ Date: _____