pharmacycouncil
Te Pou Whakamana Kaimatu o Aotearoa

Disclosure of Health Conditions

Applicant's full name:	
Date:	
Please indicate nature of health condition or impairment • Physical condition or disability • Mental illness • Addiction issues	 Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
Provide details of any diagnosis made	
Provide details of your symptoms	
Explain how your condition is managed (such as treatment plans, medication)	

Are you aware of any triggers for a relapse of your condition and if so explain your response to such insight	
Provide contact details for your treating health professional(s)	
Can the Pharmacy Council contact your doctor(s) to obtain further information	Yes ☐ No ☐
Do you believe your condition may prevent you from, or impair your ability to undertake any regular tasks carried out by a pharmacist?	Yes ☐ No ☐
If you have answered yes to the above question, please provide details	
If you have a disability do you require any special assistance in the workplace?	Yes ☐ No ☐
If you have answered yes to the above question, please provide details	

Please list, and provide copies of any reports from treating health professionals or any other supporting documentation which may fully explain your health condition that you have provided with this disclosure.	

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Evaluated by the Registrar	Yes ☐ No ☐
Affects applicant's ability to perform the functions for the practice of pharmacy	Yes ☐ No ☐
Recommendation:	
• Register applicant	Yes ☐ No ☐
• Decline applicant	Yes ☐ No ☐
• Renew APC	Yes ☐ No ☐
• Refer to Council or the Council Health Committee	Yes ☐ No ☐
Comments:	