Drugstores Association of the Philippines
Membership Profile Form

Name of Drugstore: _____

_____

Address: _____
No. Street

_____
Barangay City/Municipality

_____
Province Postal Code

Membership Code: | | | | | | | | | | |

Chapter: _____

FDA LTO No.: _____ Date Issued: _____ Expiry Date: _____

DTI Certificate No.: _____ Date Issued: _____ Expiry Date: _____

Email Address: _____ Mobile # _____ Telephone #: _____

Drugstore Classification: Regular ☐ Chain ☐ Wholesaler ☐
Distributor ☐ Franchisor ☐ Number of Branches: _____

DRUGSTORE PROFILE

Type: ☐ Counter Type ☐ Service ☐ Convenience Store

Store Hours: ☐ 24/7 ☐ Others

Location: ☐ Hospital ☐ Market ☐ Mall ☐ Neighborhood

Inventory System: ☐ POS ☐ Stock Card ☐ Stock Control Book ☐ Others

Date Established: _____

Attachments:

- ☐ ***FDA LTO Certificate***
- ☐ ***Business DTI Permit (Latest)***
- ☐ ***Mayors Permit (Latest)***
- ☐ ***SEC/Constitution & By-Laws (If Corporation/Partnership)***
- ☐ ***Picture of Drugstore with Signage***

Data Privacy Consent

I am fully aware that Drugstores Association of the Philippines (DSAP) or its designated representative is duty bound and obligated under the Data Privacy Act of 2012 to protect all my personal and sensitive information that it collects, processes, and retains upon my membership to the Association.

I understand that my personal information cannot be disclosed without my consent. I understand that the information that was collected and processed relates to my membership and to be used by DSAP to pursue its legitimate interests as an Association. Likewise, I am fully aware that DSAP may share such information to affiliated or partner organizations as part of its contractual obligation, or with government agencies pursuant to law or legal processes. In this regard, I hereby allow DSAP to collect, process, use and share my personal data in the pursuit of its legitimate interests as an Association.

_____
SIGNATURE OVER PRINTED NAME

FOR CHAIN DRUGSTORE

Name of Branch: _____ FDA LTO No. Exp. Date: _____
Address: _____
Tel. no._____ Fax No. _____ DTI Bus. Permit No._____ Exp. Date. _____
Manager / OIC: _____ Cell phone No. _____
Home Address: _____ E-mail _____
Registered Pharmacist: _____
(Name in PRC Certificate)

_____
Other Name (Maiden or Married)

PRC License No. _____ Date Issued: _____ Exp. Date. _____
Home Address: _____
E-mail Add. _____
Drugstore Set-up: ☐ Counter ☐ Self Service ☐ Counter Type
Location: ☐ in front of Hospital ☐ Market ☐ Neighborhood ☐ Mall
System: ☐ Computerized ☐ Stock Card ☐ Stock Card ☐ None
Type of Equipment: ☐ POS ☐ Cash Register ☐ Others

Name of Branch: _____ FDA LTO No. Exp. Date: _____
Address: _____
Tel. no._____ Fax No. _____ DTI Bus. Permit No._____ Exp. Date. _____
Manager / OIC: _____ Cell phone No. _____
Home Address: _____ E-mail _____
Registered Pharmacist: _____
(Name in PRC Certificate)

_____
Other Name (Maiden or Married)

PRC License No. _____ Date Issued: _____ Exp. Date. _____
Home Address: _____
E-mail Add. _____
Drugstore Set-up: ☐ Counter ☐ Self Service ☐ Counter Type
Location: ☐ in front of Hospital ☐ Market ☐ Neighborhood ☐ Mall
System: ☐ Computerized ☐ Stock Card ☐ Stock Card ☐ None
Type of Equipment: ☐ POS ☐ Cash Register ☐ Others

Pleased reproduce if needed.(For more than 2 branches)

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_____
SIGNATURE OVER PRINTED NAME

Drugstores Association of the Philippines
Owner Profile Form

Owner's

PASSPORT SIZE I.D. PICTURE

Name of Owner: _____

Address: _____

No. Street

_____

Barangay City/Municipality

_____

Province Postal Code

Telephone Number: _____ Cell phone Number:_____

Email Address: _____ Fax Number: _____

Birth date: _____ Gender: ☐ Male ☐ Female

Status: ☐ Single ☐ Married ☐ Widowed/Widower ☐ Divorced ☐ Others

EDUCATIONAL ATTAINMENT

	College/University	Course	Year Graduate
College			
Masters			
Doctorate			
Special Program			
Others			

Attachment:

☐ ***Any Government Issued ID***

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_____

SIGNATURE OVER PRINTED NAME

Drugstores Association of the Philippines
Representative Profile Form

Representative's

PASSPORT SIZE I.D. PICTURE

Name of Representative: _____

Address:_____

No. Street

_____

Barangay City/Municipality

_____

Province Postal Code

EDUCATIONAL ATTAINMENT

	College/University	Course	Year Graduate
College			
Masters			
Doctorate			
Special Program			
Others			

CERTIFICATE OF AUTHORIZATION

This is to certify that

_____

(Name of appointed Representative)

Is the official REPRESENTATIVE for my drugstore.He/She is authorized to act for and on behalf of my drugstore in matters relating to DSAP.

This authorization takes effect this ____ day of _____, 2018 and will remain in force until revoked by me in writing.

_____

(Name & Signature of Registered Owner)

Signature of Authorized Representative : _____

DRUG STORE TRADE NAME : _____

LTO License No. : _____

REGISTERED OWNER'S NAME : _____

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_____

SIGNATURE OVER PRINTED NAME

Drugstores Association of the Philippines
FOR DSAP ID ISSUANCE

DRUGSTORE OWNER / REPRESENTATIVE

***PLEASE PRINT IN CAPITAL LETTERS**

FULL NAME:

_____

Surname First Name M.I.

DRUGSTORE NAME:

_____

_____

EMAIL ADDRESS: _____

CELLPHONE NUMBER: _____

PASSPORT SIZE
I.D. PICTURE

Signature @ the box

Please use black pen/marker

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_____

SIGNATURE OVER PRINTED NAME

Drugstores Association of the Philippines
DRUGSTORE PHARMACIST FORM

Pharmacist's

PASSPORT SIZE I.D. PICTURE

Name of Pharmacist: _____
Surname First Name M. I.

Address: _____
No. Street Barangay

_____
City Province Postal Code

Birthday: _____ Status: _____ ( ) Female ( ) Male
DD/MM/YY

E-mail Add: _____ Tel. No._____ Cell No. _____

Registered Pharmacist: _____
(Name in PRC Certificate)

_____
Other Name (Maiden or Married)

PRC License No. _____ Date Issued: _____ Exp. Date. _____

Educational Attainment

	College / University	**Course**	**Year Graduated**
College			
Masters			
Doctorate			
Special Program			
Others			

Other Organization: _____

_____

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_____
SIGNATURE OVER PRINTED NAME

Drugstores Association of the Philippines
DRUGSTORE PHARMACY ASSISTANT FORM

Pharmacy Assistant's

PASSPORT SIZE ID Picture

Name of Pharmacy Assistant:_____
Surname First Name M. I.

Address: _____
No. Street Barangay

_____
City/Municipality Province Postal Code

Birthday: _____ Status: _____ ( ) Female ( ) Male
DD/MM/YY

E-mail Add: _____ Tel. No._____ Cell No. _____

Employer: _____

Address: _____

Years of service as P.A _____

Educational Attainment

	College / University / School	Course	Year Graduated
Primary			
Secondary			
College			
Masters			
Doctorate			
Special Program			
Others			

Other Organizationaffiliated (social, civic, NGOs)

_____

PLEASE ATTACH REQUIRED FORMS:

1. Certificate of Employment from the drugstore indicating number of years as Pharmacy assistant.
2. Diploma
3. Certificate of Attendance to Seminars (P.A. Summit, CEPPHA Certificate of Attendance, Swipe Rx Certificate, etc,)

Pleased reproduce if needed.

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_____
SIGNATURE OVER PRINTED NAME