



# Drugstores Association of the Philippines Membership Profile Form

Name of Drugstore: \_\_\_\_\_

Address: \_\_\_\_\_

No.

Street

Barangay

City/Municipality

Province

Postal Code

Membership Code:

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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

***Pl eased reproduce if needed.(For more than 2 branches)***

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\_\_\_\_\_  
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# 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 \_\_\_\_\_, 2020 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

Pharmacists  
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 Organization affiliated (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.)

***Plensed reproduce if needed.***

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