EMERGENCY CARE SERVICE PROVIDERS CONFIRMATION OF RESPONSIBLE DOCTOR AFFILIATION FORM

DETAILS TO BE COMPLETED AND SIGNED BY EMERGENCY CARE SERVICE PROVIDER	
REGISTERED BUSINESS NAME:	
BUSINESS REGISTRATION NUMBER:	
NAME AND SURNAME OF RESPONSIBLE PARAMEDIC:	
IDENTIFICATION NUMBER OF RESPONSIBLE PARAMEDIC:	
QUALIFICATION:	
HPCNA REGISTRATION NUMBER:	

Operating as emergency care service providers within Namibia, hereby declare that our appointed responsible doctor and overseer of daily operations as emergency care service providers is:

DETAILS TO BE COMPLETED AND SIGNED BY AFFILIATED MEDICAL DOCTOR	
NAME AND SURNAME OF RESPONSIBLE DOCTOR:	
IDENTIFICATION NUMBER OF RESPONSIBLE DOCTOR:	
QUALIFICATION:	
HPCNA REGISTRATION NUMBER:	

We hereby declare that the above information is true and correct and acknowledge accept all responsibility relating to the procurement and use of scheduled medicines under the supervision and affiliation of the medical doctor.

For and on behalf of emergency care service provider: _____

Name and Surname: _____

For and on behalf of medical doctor: _____

Name and Surname: _____

Initial here - Applicant	*Initial here - Nampharm*