# PHARMACY ASSISTANT TRAINEE FEEDBACK REPORT

## Pharmacy Details

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| Pharmacy Name: |       |
| Pharmacy Owner: | Given Name(s)      | Family Name      |
| Pharmacy Address: | Physical address      |
| Suburb      | State      | Postcode      |
| Phone Number: |       |
| Email Address: |       |

## Pharmacy Assistant Trainee Details

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| --- | --- | --- |
| Name: | Given Name(s)      | Family Name      |
| Phone Number: |       |
| Email Address: |       |

## 1. Do you plan to continue working as a Pharmacy Assistant?

[ ]  Yes [ ]  No

If yes, please provide the pharmacy name and address where you will be working.

|  |  |
| --- | --- |
| Pharmacy Name: |       |
| Pharmacy Address: | Physical address      |
| Suburb      | State      | Postcode      |

## 2. Has this experience encouraged you to undertake further studies?If so, please provide the details.

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## 3.Please provide any other comments you would like to make in relation to the ATSI PATS Allowance:

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|       |

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| Signature: |       | Date: |       |
| Full name: |       |

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|  | CONTACT THE SUPPORT CENTRE: 1800 951 285 | support@ppaonline.com.au |