# 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

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

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