**CONSELHO FEDERAL FARMÁCIA**



**Conselho Regional de Farmácia do Estado de Pernambuco**

**Rua Amélia, 50 - Espinheiro - 52020-150 - Recife/PE
PABX: (81) 3426-8540 | CNPJ: 09.822.982/0001-71
 www.crfpe.org.br | secretaria@crfpe.org.br**

Protocolo Nº\_\_\_\_\_\_\_\_\_

Data\_\_\_/\_\_\_/\_\_\_\_

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REQUERIMENTO

O(a) **Farmacêutico(a)/Técnico(a):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CRF/PE:\_\_\_\_\_\_\_\_ Endereço:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bairro:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Município:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CEP:\_\_\_\_\_-\_\_\_ Fone:\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vem requerer:

01. ( ) Inscrição Definitiva \ Registro de Diploma

02. ( ) Inscrição por Transferência

03. ( ) Alteração de Horário

04. ( ) 2ª Via da Carteira de Identidade Profissional

05. ( ) Inscrição Técnico em Laboratório

06. ( ) Inscrição Provisória

07. ( ) Justificativa de Falta à Eleição

08. ( ) Alteração de Endereço

09. ( ) Transferência

10. ( ) Inscrição Secundária

11. ( ) Outros

Observações:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

O(a) **Sócio/Proprietário(a) :**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Razão Social:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CRF/PE:\_\_\_\_\_\_\_\_\_ Endereço:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bairro:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Município:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CEP:\_\_\_\_\_-\_\_\_ Fone:\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vem requerer:

01. ( ) Alteração de Razão Social

02. ( ) Alteração de Horário

03. ( ) Alteração de Contrato Social

04. ( ) Visto de Rescisão de Contrato

05. ( ) Alteração de Endereço

06. ( ) Cancelamento de Inscrição

07. ( ) Suspensão de Atividade

08. ( ) Outros

Observações:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_, \_\_\_ de \_\_\_\_\_\_\_\_\_\_\_ de 20\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Profissional CRF-PE (\_\_\_\_\_\_\_\_) Proprietário/Representante Legal Depto. de Fiscalização CRF-PE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Presidente do CRF-PE**

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**Ilmo. Sr. Presidente do Conselho Regional de Farmácia do Estado de Pernambuco.**

**Venho requerer a Cédula de Identidade Profissional nos termos da Resolução CFF 428/2004.**

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Inscrição CRF-PE

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| Nacionalidade: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Naturalidade: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | UF: |  |  |

5 - Viúvo(a)

6 - União Estável

7 - Outros

8 - Não Informado

1 - Solteiro(a)

2 - Casado(a)

3 - Divorciado(a)

4 - Desquitado(a)

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| Estado Civil: |  |

 Conclusão do Curso

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| Data Conclusão: |  |  | / |  |  | / |  |  |  |  |

Instituição de Ensino

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| Grupo Sangüíneo: |  |  |  | Fator Rh: |  |  1 – Positivo / 2 - Negativo | Doador de órgãos: |  |  1 – Sim / 2 - Não |

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| Cidade: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  UF: |  |  |

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| Cep: |  |  |  |  |  | - |  |  |  |  |  | F.Residencial: | ( | ) |  |  |  |  | - |  |  |  |  |

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| Celular: | ( | ) |  |  |  |  | - |  |  |  |  | F.Comercial: | ( | ) |  |  |  |  | - |  |  |  |  |

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| E-mail: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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Dados biométricos (**Preencher presencialmente no ato da solicitação**)

Impressão digital do dedo polegar
Pousada exatamente dentro do campo com tinta preta

Foto 3 X 4 recente com fundo branco

Assinatura da Carteira

Assinar no espaço delimitado, com caneta preta ou azul de ponta grossa.

As informações prestadas pelo profissional deverão ser completas, exatas, precisas e verdadeiras, e este assume o compromisso de atualizar seus dados sempre que houver alguma alteração, bem como toda e qualquer responsabilidade relativa às informações prestadas. Os profissionais garantem e respondem, em qualquer caso, pela veracidade, exatidão e autenticidade dos dados informados.

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 Local Data Assinatura