Affix Passport size picture here

OVER-THE-COUNTER MEDICINE PRACTITIONER'S OPERATING LICENCE APPLICATION FORM

HEALTH PROFESSIONS REGULATORY BODIES ACT, 2013 (ACT 857), SECTION 94

1. PERSONAL DATA

I, ... apply for a licence

(SURNAME) (First Name) (Middle Name)

to supply by retail ONLY Over- the -Counter Medicines i.e. (Class C medicines)

POSTAL ADDRESS:	TELEPHONE: FAX: E-MAIL:

NATIONALITY

DATE OF BIRTH

DAY	MONTH	YEAR

AGE

SEX

MALE FEMALE

RESIDENTIAL ADDRESS: (H/No., Street, Suburb etc.)	POSTAL ADDRESS	TELEPHONE: FAX: E-MAIL:

QUALIFICATION

CERTIFICATE	INSTITUTION	YEAR OBTAINED

EMPLOYMENT DATA (on last 2 places of work)

INSTITUTION	POSITION HELD	FROM – TO

PRESENT OCCUPATION:...

I certify that all the information I have provided above is correct.

....

SIGNATURE DATE

PLEASE NOTE: Any false declaration or the provision of any false information will render this application invalid.

NOT FOR SALE

2. LOCATION DETAILS

NAME OF APPLICANT:...

LOCATION ADDRESS

H/No. ....

Street name:..

Landmark...

Suburb:..

Town:...

District:...

Region:...

GPS ....

NAME OF NEAREST PHARMACY OR OTCMS	RELATIVE DISTANCE FROM PROPOSED LOCATION
1.	
2.	
3.	

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PROVIDE SKETCH OF LOCATION

NB: THE PROPOSED LOCATION SHOULD BE A MINIMUM OF 1 KM (BY RADIUS) FROM THE NEAREST PHARMACY OR OVER-THE-COUNTER MEDICINE SELLERS' FACILITY

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3. REFEREE'S DECLARATION

This form should be filled by a referee nominated by the applicant. The referee should either be a Pharmacist, a Senior Civil or Public Officer not below the rank of a Principal Executive Officer, a Senior Medical Officer or a Leader of a recognised religious body.

I .... have known
(name of referee)

capacity as .... I have no doubt that all the
(state relationship with applicant)

applicant's personal data provided are true and accurate. I am convinced that the applicant is capable of adhering to the rules and regulations that go with operating a Over-the-Counter medicines Seller's facility.

I also confirm that the picture endorsed by me is the true likeness of the applicant. I therefore recommend him/her to be considered for the licence.

.... Signature of Referee

.... Position

.... Date

.... Official Stamp

Referee's Contact Address:	Telephone: Fax: E-Mail:

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FOR OFFICIAL USE ONLY (not to be filled by applicant)

1. LOCATION INFORMATION IN RESPECT OF ....
(NAME OF APPLICANT)

2. LOCATION ADDRESS
H/No. ....
Street name:...
Landmark...
Suburb:..
Town:..
District:...
GPS: Latitude: ....
Longitude: ....
Degrees: ....
Altitude: ....

3. How far are the three (3) nearest facilities from the proposed site?

   Indicate in part A & B of the table below.

4. Has any application been received near the proposed location? Yes ☐ No ☐

   If yes, fill in part C of the table below.

	NAME OF PHARMACY	RELATIVE DISTANCE
A		
B	NAME OF OTCMS	RELATIVE DISTANCE
C	NAME OF OTCMS APPLICANT RECEIVED	RELATIVE DISTANCE

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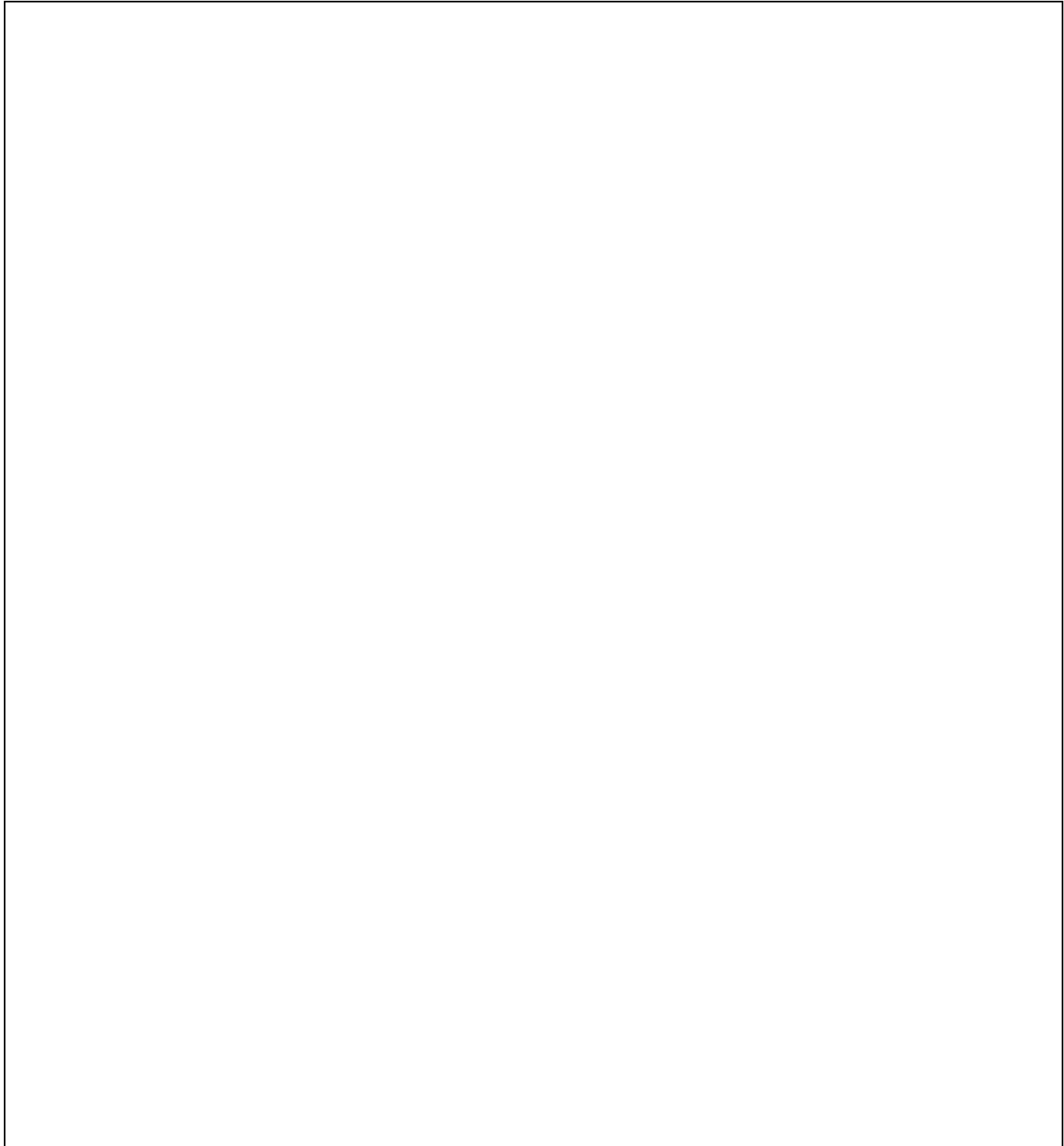
5. Sketch below showing the relative positions and distances of the proposed location to the existing facilities/Landmark.



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6. APPROXIMATE POPULATION SUBURB ....

7. What peculiar activity is within/around the proposed site? (e.g. Market, Lorry Station etc.)
   ....

8. Room dimension: Length..........................Width.......................Height.............................

   Total Floor Space ....

9. Any other comments:
   ....
   ....
   ....
   ....
   ....
   ....
   ....
   ....
   ....
   ....
   ....
   ....
   ....

10. Recommendation:...

....
NAME OF INSPECTOR SIGNATURE

....
DATE

....
NAME OF REGIONAL MANAGER SIGNATURE

....
DATE

REGISTRATION COMMITTEE'S RECOMMENDATION	COUNCIL'S DECISION
☐ Recommended ☐ Not Recommended ☐ Deferred ☐ Referred to Council SIGN:.. DATE:..	☐ APPROVED ☐ NOT APPROVED ☐ Deferred SIGN:..................................... DATE:.....................................

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NAME OF INSPECTOR OR AUTHORIZED OFFICER	

CODE NUMBER	

SIGNATURE	
DATE OF RECEIPT	

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ACKNOWLEDGEMENT SLIP (TO BE DETACHED AND GIVEN TO APPLICANT)

DATE OF RECEIPT NAME OF INSPECTOR/AUTHORISED OFFICER

....

CODE NUMBER	
TIME	

SIGNATURE:

OFFICIAL STAMP

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(TO BE DETACHED AND GIVEN TO APPLICANT)

IN CASE OF ENQUIRES CONCERNING THIS APPLICAION, PLEASE CONTACT COUNCIL ON THE FOLLOWING CONTACTS AS APPLICABLE TO YOU.

HEAD OFFICE: P.O. BOX AN 10344, ACCRA-NORTH, GHANA,
TEL: (0302) 680150/681929; FAX: (233-0302) 681931
Website: www.pcghana.org E- mail: - info@pcghana.org

REGION	CONTACT	LOCATION/ADDRESS
Greater Accra	(233) (0302) 681929, 680150	The Regional Manager Pharmacy Council Kwame Nkrumah Avenue Near Adjabeng Court P.O. Box AN 10344 , Accra-North
Eastern Region	(03420) 23205	The Regional Manager Pharmacy Council 2nd Floor SIC Office Complex P.O. Box KF 2228, Koforidua
Volta Region	(03620) 26324	The Regional Manager Pharmacy Council Old School of Hygiene P.O. Box HP 1266, Ho
Central Region	(03321) 33233	The Regional Manager Pharmacy Council SIC Building Complex P.O. Box CC 1339, Cape Coast
Western Region	(03120) 46391	The Regional Manager Pharmacy Council Regional Health Administration P.O. Box 1261, Takoradi
Ashanti Region	(3220) 31636, 41455	The Regional Manager Pharmacy Council Regional Health Administration P.O. Box KS 778, Kumasi
Brong Ahafo Region	(03520) 26551, 26490	The Regional Manager Pharmacy Council Near PWD P.O. Box 744, Sunyani
Northern Region	(03720) 23061	The Manager Pharmacy Council Tamale Old Hospital P.O. Box TL 1777, Tamale
Upper East Region	(03820) 29208	The Regional Manager Pharmacy Council Services Building P.O. Box BG 869, Bolgatanga
Upper West Region	(03920) 22842	The Regional Manager Pharmacy Council 2nd Floor, C&AG Block P.O. Box 179, Wa

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