APPLICATION FOR RENEWAL OF REGISTRATION FOR PHARMACY BUSINES

LIC.NO. PC/…….. DATE: ……

NAME OF BUSINESS: ……

LOCATION OF BUSINESS: ……

(H/No. Street, Suburb, Town, etc)

TYPE OF PHARMACY ☐ COMMUNITY PHARMACY ☐ HOSPITAL/CLINIC PHARMACY

If Community Pharmacy, tick the appropriate business type
☐ RETAIL ☐ WHOLESALE ☐ WHOLESALE/RETAIL ☐ MANUFACTURING WHOLESALE

OWNERSHIP OF PHARMACY BUSINESS ☐ GOV'T ☐ PRIVATE ☐ MISSION/NGO

BUSINESS POSTAL ADDRESS

	TEL/MOBILE NO. FAX E-MAIL ADDRESS

BUSINESS WORKING HOURS

MONDAY-FRIDAYS	SATURDAYS	SUNDAYS

SUPERINTENDENT PHARMACIST

NAME	REG. NO.	YEAR OF REG.	WORKING HOURS	SIGNATURE

EMPLOYMENT DATA, STATE LAST TWO PLACES OF WORK

Community Pharmacy	NAME OF INSTITUTION	POSITION HELD	YEAR/FROM – TO	WORKING HRS

EMPLOYMENT DATA, STATE ANY OTHER CURRENT PLACE OF WORK

Hospital Practice				
Medical Representative				
Academia				
Regulatory				
Others (Please specify)				

NB: TO BE SUBMITTED BY THE SUPERVISING PHARMACIST

LIST OF PHARMACISTS & PHARMACY SUPPORT STAFF IN THE FACILITY

No	Name (Surname first)	Practitioner type (P'cist/PTs/MCA)	Reg No/PIN	Year of Registration	Number of years of Practice

(It is mandatory to register all your pharmacists and pharmacy support staff)

TO BE COMPLETED BY PROPOSED SUPERVISING PHARMACIST

I WISH TO CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND HEREBY ACCEPT TO BE THE SUPERVISING PHARMACIST FOR THE BUSINESS.

…… …….

(NAME) (REGISTRATION NUMBER)

…….. ……

(SIGNATURE) (DATE)

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS:.....

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INSPECTOR:.....

SIGNATURE:..... **DATE:**.....