PHARMACY COUNCIL OF THE GAMBIA
No. 112 Kairaba Avenue
Fajara , KMC
Tel: 4495572, 2022272 P.O.Box 4527 Bakau
Website: www.gpc.gm

PREMISES LICENSING APPLICATION FORM

New License ☐

Renewal ☐ **Relocation of Premise** ☐ **Change of Supervisor** ☐

License No: _____ **(*attach copy*)**

Wholesale Pharmacy ☐ **Retail Pharmacy** ☐ **Drugstore** ☐

Veterinary Drugstore ☐ **Supermarket Permit** ☐

A: PARTICULARS OF SUPERVISOR

TITLE _____ **(Ms, Mr, Mrs, Pharm, Dr, Prof)**

FAMILY NAME/SURNAME	**FORMER/MAIDEN NAME (if any)**

FIRST NAME(S)

DATE OF BIRTH (DD/MM/YYYY)	**NATIONALITY**

	RESIDENTIAL ADDRESS	**POSTAL ADDRESS**
Town/Area		

TELEPHONE NUMBER		**E-MAIL ADDRESS**
Landline Mobile		

B: PARTICULARS OF PREMISE AND APPLICANT

Name of premise: _____

SUPERVISOR TO PROVIDE REGISTRATION NUMBER(S) OF

Pharmacy Council: _____(*attach copy*)

or Veterinary Council: _____(*attach copy*)

For Nurse Dispenser also NMC: _____(*attach copy*)

Location of Premise:_____

_____

FOR NEW LICENSE ONLY

Business Registration #:_____

Tax Identification # (*attach copy*):_____

FOR RENEWAL ONLY

When was the last inspection of your premise conducted by PCG Inspectorate?

_____/_____(**month/year**)

(*Attach copy for evidence*):_____

Has there been any change in any of the following particulars of the premise:

Signboard:	Yes ☐	No ☐
Dispensing area:	Yes ☐	No ☐
Shelves & counters:	Yes ☐	No ☐
Controlled medicines safe:	Yes ☐	No ☐
Counselling room:	Yes ☐	No ☐

Other change(s) to declare: _____

_____

_____

_____

_____

_____

_____

C: PARTICULARS OF PROFESSIONAL STAFF

Aside the supervisor, list all staff that are involved in the pharmaceutical services (***wholesaling, compounding, packing & labeling, dispensing, counselling, etc.***) offered by the premise; C1 for staff registered with PCG and C2 for staff not registered with PCG:

C1: staff registered with Pharmacy Council

#	**Name**	**Cadre**	**PCG Reg. #**

C2: staff not registered with Pharmacy Council but offering pharmaceutical services

#	**Name**	**Qualification** (*attach copy of certificate*)	**Years of experience**

NB: provide as attachment when more than four staff per premise

FOR SUPERVISOR - DO YOU OWN THIS PEMISE? YES □ NO □

DECLARATION:

I, the undersigned certify that the information in the accompanying documentation concerning the application for licensing indicated herein is correct and true.

Please indicate submitted documents on the last page! Application is complete when all the applicable information and required documents are submitted.

Signature of Supervisor: ..... **Date:** .....

FOR OFFICIAL USE

DATE OF RECEPTION:		STAMP
NAME OF RECEIVER:		
NAME OF REGISTRAR		
REMARKS/RECOMMENDATIONS OF REGISTRAR:		
Signature:	Date:	

ATTACHMENTS CONFIRMATION	**SUBMITTED by Supervisor**	**CONFIRMED by PCG**
Application form (signed and dated) *NB: mandatory else not application is filed*	*Please tick where applicable*	☐
Copy of Supervisor national identity ***(for new premise only)***	☐	☐
Copy of premise year's license	☐	☐
Copy of Business registration ***(for new premise only)***	☐	☐
Copy of TIN ***(for new premise only)***	☐	☐
Supervisor's current Registration certificate with Pharmacy Council *NB: previous year's certificate accepted for applications filed on or before 31st march of application year*	☐	☐
Copy of current registration certificate with NMC ***(Nurse Dispenser only)***	☐	☐
Copy of current registration certificate with Veterinary Council ***(veterinary practitioners only)***	☐	☐
Copies of certificates of non-PCG registered staff	☐	☐