



## **PREMISE LICENSING APPLICATION FORM**

New Licence ☐

Renewal ☐

Licence No: ..... (attach copy)

Wholesale Pharmacy ☐

Retail Pharmacy ☐

Drugstore ☐

Veterinary Drugstore ☐

Supermarket Permit ☐

### **A. PARTICULARS OF SUPERVISOR**

SEX: Male ☐ Female ☐

TITLE \_\_\_\_\_ (Ms, Mr, Mrs, Pharm, Dr, Prof)

FAMILY NAME/SURNAME

FORMER/MAIDEN NAME (if any)

--	--

FIRST NAME(S)

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DATE OF BIRTH (DD/MM/YYYY)

NATIONALITY

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RESIDENTIAL ADDRESS

POSTAL ADDRESS

Town/Area:		
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TELEPHONE NUMBER

E-MAIL ADDRESS

Landline		
Mobile		
WhatsApp		

**B PARTICULARS OF PREMISE AND APPLICANT**

Name of premise: \_\_\_\_\_

For **Supervisor's** Registration Number of:

Pharmacy Council: \_\_\_\_\_(attach copy)

or Veterinary Council: \_\_\_\_\_

Signature, date and stamp: \_\_\_\_\_

For Nurse Dispenser also NMC: \_\_\_\_\_(attach copy)

**Location of Premise:** \_\_\_\_\_**FOR NEW LICENCE ONLY**

Business Registration #: \_\_\_\_\_

Tax Identification #: \_\_\_\_\_(attach copy)

**FOR RENEWAL ONLY**

When was the last licensing inspection conducted by PCG Inspectorate?

\_\_\_\_\_/\_\_\_\_\_(month/year)

Has there been any change in any of the following particulars of the premise in the last year?

**Signboard layout and/or information:** 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 (*compounding, dispensing, selling or counselling, etc*) offered by the premise:

### *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

**FOR SUPERVISOR: DO YOU OWN THIS PREMISE?** 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!*

**Signature of Applicant:** ..... **Date:** .....

**OFFICIAL USE**

<b>DATE OF RECEPTION:</b>		<b>STAMP</b>
<b>NAME OF RECEIVER:</b>		
<b>NAME OF REGISTRAR</b>		
<b>REMARKS/RECOMMENDATIONS BY REGISTRAR</b> ..... ..... .....		
<b>Signature:</b> ..... <b>Date:</b> .....		

<b>ATTACHMENTS CONFIRMATION</b>	<b>SUBMITTED by applicant</b>	<b>CONFIRMED by PCG</b>
Application form (signed and dated)	<input type="checkbox"/>	<input type="checkbox"/>
Copy of ..... for identification <i>(for new licence only)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Business registration <i>(for new licence only)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Copy of TIN <i>(for new licence only)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Copy of premise licence (for renewals only)	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Pharmacy Degree Certificate (Pharmacists)	<input type="checkbox"/>	<input type="checkbox"/>
Supervisor's current Registration certificate with Pharmacy Council	<input type="checkbox"/>	<input type="checkbox"/>
Copy of current registration certificate with NMC <i>(Nurse Dispenser only)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Copies of certificates of non-PCG registered staff	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): ..... ..... .....	<input type="checkbox"/>	<input type="checkbox"/>