



PHARMACY COUNCIL OF THE GAMBIA

Off Kairaba Avenue
Pipeline (opposite Mosque), Serrekunda
Tel: (+220) 4383841, 7690904, 7382655; P.O.Box 4527 Bakau



Website: www.gpc.gm, Email: info@gpc.gm

CHANGE OF PREMISE LICENSING APPLICATION FORM

Relocation of Premise Change of Name of Premise Change of Supervisor

Current Licence No: (attach copy)

A. PARTICULARS OF CURRENT SUPERVISOR AND PREMISE

FAMILY NAME/SURNAME

FORMER/MAIDEN NAME (if any)

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FIRST NAME(S)

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TELEPHONE NUMBER

E-MAIL ADDRESS

Landline		
Mobile		
WhatsApp		

SUPERVISOR'S REGISTRATION NUMBER of:

Pharmacy Council: _____

or Veterinary Council: _____

For Nurse Dispenser also NMC: _____

NAME OF PREMISE: _____

LOCATION OF PREMISE: _____

B. PARTICULARS OF PLANNED SUPERVISOR AND/OR PREMISE**For change in Supervisor only****SEX:** Male Female **TITLE** _____ (Ms, Mr, Mrs, Pharm, Dr, Prof) _____**FAMILY NAME/SURNAME****FORMER/MAIDEN NAME (if any)**

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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		

Planned Supervisor's Registration Number of:

Pharmacy Council: _____ (attach copy)

or Veterinary Council: _____

Signature, date and stamp: _____

For Nurse Dispenser also NMC: _____ (attach copy)

Will he/she own this premise?Yes No For change of name of premise **planned Name:** _____For change of location of premise **planned Location:** _____

DECLARATION:

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

Please indicate submitted documents below!

Signature of Applicant: **Date:**

OFFICIAL USE

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

ATTACHMENTS CONFIRMATION	SUBMITTED by applicant	CONFIRMED by PCG
Application form (signed and dated)	<input type="checkbox"/>	<input type="checkbox"/>
Copy of for identification	<input type="checkbox"/>	<input type="checkbox"/>
Copy of current premise licence	<input type="checkbox"/>	<input type="checkbox"/>
Copy of Business registration	<input type="checkbox"/>	<input type="checkbox"/>
Copy of planned Supervisor’s Registration certificate with Pharmacy Council (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>
Copy of registration certificate with NMC for planned Nurse Dispenser (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>
.....		
.....		