Quality Medicines for Malawi

APPLICATION FORM

DISPENSING PREMISES RELOCATION

DOC. NO.:

1. Name of Clinic/ Hospital____

2. Registration status *(attach copy of registration certificate)* ________________________________

3. Email address____

   Phone number____

4. Previous location of the premises____
5. New Location of clinic/hospital *(city/town, street, plot no.)* include a sketch map at the back

   ____

6. Postal Address :____

7. Name and registration number of the clinician *(attach copy of valid registration certificate)*

   ____

8. Name, qualifications, experience and registration status of dispenser: *(attach copy of valid registration certificate with PMRA or Nurses and Midwives Council of Malawi)*

   ____

7. I submit this application for your consideration.

   DATE_____/_____/_______ Signature of applicant______________________________

8. FOR OFFICE USE ONLY

(a) Date of inspection ____

(b) Remarks ____

(c) Receipt of Re-location fees ____

(d) Receipt of inspection fees ____

(e) Date of approval ____/_____/_____

(f) Licence No ____

Date ______/_____/_______ Signature ____

Director General___________________________

Pharmacy and Medicines Regulatory Authority

(* NOTE: 1. Fees once paid are non-refundable.