Quality Medicines for Malawi

APPLICATION FORM

DOWNGRADING RETAIL PHARMACY TO MEDICINE STORE

DOC. NO.:

1. Name of Retail Pharmacy to be downgraded_____

2. Name of the Medicine Store _____

3. Proposed Retail Pharmacy where the Prescription Only Medicines (POMs) will be transferred

to_____

4. Email address _____

5. Phone number _____

6. Postal address _____

7. Location of premises on which a medicine store business is to be carried out (city/town, street, plot no.) include a sketch map at the back _____

8. Where the applicant is a company:

(a) state the registration number of company under the Act: _____

(b) state the name and registration number of the person under whose personal management and control affairs of the company would be subject to:

(i) Name: _____

(ii) Registration No.: _____

(c) attach a copy of the certificate of incorporation of the company:

9. Name and registration number of a full time pharmacy personnel having control of the premises referred to in paragraph 2:

(i) Name: _____ (ii) Registration No.: _____

10. I, the above mentioned applicant, submit this application form for your consideration

Date: _____/_____/_____ Signature of applicant_____

11. **FOR OFFICE USE ONLY:**

(a) (i) Registration fee of MK._____ Receipt No._____

(b) (ii) Inspection fee of MK _____ Receipt No. _____

(c) Date of inspection of premises: _____/_____/_____

(d) Remarks:_____

(e) Date of approval of application: _____/_____/_____

(f) Registration No.:_____

Date: _____/_____/_____ Signature: _____

Director General_____
Pharmacy and Medicines Regulatory Authority

All applications should be addressed to:
The Director General, Pharmacy and Medicines Regulatory Authority, P.O Box 30241,
CAPITAL CITY LILONGWE 3, MALAWI.