Quality Medicines for Malawi

APPLICATION FORM

MEDICINE STORE RELOCATION

DOC. NO.:

1. Name of applicant: _____

2. Name of Business: _____

3. Email address: _____

   Phone number: _____

4. Previous location of the medicine store: _____
5. Location of premises where the medicine store business is to be re-located (city/town, street, plot no.) include a sketch map at the back: _____
6. Postal Address: _____
7. 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:

8. Name and registration number of the full time pharmacy personnel having control of the premises referred to in paragraph 4:

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

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

   Date:_____/_____/_____ _____
   Signature of applicant

10. **FOR OFFICE USE ONLY:**
    (a) (i) Re-location 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.