

APPLICATION FOR REGISTRATION OF NEW PHARMACY PREMISES

Please tick appropriate box below:

1. Sole Trader Ltd Company Partnership Hospital

2. Name of Body Corporate (if Sole trader or Partnership, go to 3)

2b. Certificate of Incorporation no.

3. Print full name of Owner(s) or Superintendent

Surname

Forename(s)

Pharmacist Registration No.

4. Full Postal Address of Premises to be Registered

Trading Name

Number Street

Town

County Postcode Telephone Number

5. Registered name of manager of premises

Registration No.

6. Health Board (W/S/E/N) Please delete HS Contract YES/NO

7. DATE FROM WHICH PREMISES WILL BE READY FOR INSPECTION

8. PROPOSED DATE OF OPENING

9. ENCLOSE REGISTRATION FEE OF

10. PLEASE ENCLOSE* 2 COPIES OF PLANS OF THE AREA TO BE REGISTERED (OUTLINED IN RED)

11. Write a brief description of the internal layout describing where medicines are to be sold, supplied, prepared, dispensed or stored to supplement the attached plans if appropriate

12. Pharmacist to contact concerning this application

Name Daytime Tel No:

I declare the premises are arranged to enable the responsible pharmacist to exercise supervision over dispensing, sale of medicines and all pharmacy procedures.

Signature Date

*Please ensure you have enclosed two copies of the plans drawn to scale