PHARMACY COUNCIL

P.O. Box CP 6134
Conway Post Office
Castries LC 04 301

Tel: (758) 468-5311

Mobile (758) 461-2668

Email: pharmacycouncilslu@gmail.com

Website: www.pharmacycouncilslu.org

INSTRUCTIONS: *Applicant: Fill out the following blanks. Type or print in ink. Return to the PHARMACY COUNCIL at the address listed above.*

FOR OFFICE USE ONLY	
Receipt number	
Fee **$525**	Date
Registration number	
Date inspected	Date issued

APPLICATION FOR REGISTRATION AS A PHARMACY

PHARMACY INFORMATION	PHARMACY OWNER INFORMATION	
Name of pharmacy	Name of pharmacy owner *(If corporation or partnership attach a list of officers on a separate sheet including, name, address or title)*	
Address of pharmacy	Address of owner	
Telephone number	Telephone number	Fax
Fax	Social Security number	
Email	Email	
Mailing address	Mailing address	

Has the owner, or any corporate officer or partner ever been convicted of an offence involving moral turpitude, a felony offence, or any drug-related offence or has any currently pending felony or drug-related charges, and if so, indicate charge, conviction date, jurisdiction and location.

☐ Yes ☐ No

Name of Pharmacist in charge		
Name of school or college of pharmacy of Pharmacist in charge	Qualifications obtained	Date obtained
License number of Pharmacist in charge	Expiration date	Tel No.
Address		
Mailing address *(If applicable)*		
Email		

I, ____ hereby swear or affirm under the penalties of perjury that the statements
(Name of owner)
made in this application for Registration as a Pharmacy are true and correct in all respects.

Authorised Signature ____ Date _________________________________

Title__________________________________