REPUBLIC OF LIBERIA
MINISTRY OF HEALTH (MOH)
PHARMACY BOARD OF LIBERIA
P.O. BOX 10-9009
1000 MONROVIA 10-LIBERIA
WEST AFRICA

PLEASE TYPE ALL INFORMATION

JANUARY-DECEMBER 2024

REGISTRATION FORM

Medicine Store

County: _____ Code. _____

Name of Medicine Store _____
(MEDICINE STORE)

Location: _____

Proprietor/Proprietress: _____ County: _____
Cell No: _____ Email: _____
Proprietor/Proprietress: _____ County: _____
Cell No: _____ Email: _____

Dispenser's Name: _____ County: _____
Cell No._____ Email: _____
Qualification: _____ **LPB #:** _____

Dispenser's Name:_____ County: _____
Cell No._____ Email: _____
Qualification: _____ **LPB #:** _____

Approved: _____ Date: _____
Proprietor / Proprietress

PBL Use Only
Date Submitted: _____

E-mail: pharmacyboardliberia@yahoo.com

REPUBLIC OF LIBERIA
MINISTRY OF HEALTH (MOH)

PHARMACY BOARD OF LIBERIA

CLAY'S BUILDING, SEKOU TOURE AVENUE-MAMBA POINT
1000 MONROVIA- 10 LIBERIA
P.O. BOX 10-9009
WEST AFRICA

Our Ref. No.

JANUARY-DECEMBER 2024

PLEASE TYPE ALL INFORMATION

Name of Medicine Store: _____ Identification / Code: _____

Address: _____

I. D. PHOTO

Name: _____
County: _____
Position: _____
Telephone #s: _____
Holder's Signature: _____

I. D. PHOTO

Name: _____
County: _____
Position: _____
Telephone #s: _____
Holder's Signature: _____

I. D. PHOTO

Name: _____
County: _____
Position: _____
Telephone #s: _____
Holder's Signature: _____

Approved: _____ Date: _____

Email: pharmacyboardliberia@yahoo.com

PROPRIETORATE

1. Name(s) of Proprietor/Proprietress: _____ County: _____
Address: _____ Cell#: _____
I _____, Proprietor/Proprietress of _____

Do hereby apply to the Board for the year _____ and hereby vow to serve only as proprietor and not as a Dispenser of said entity, and also vow to sell only over the counter (OTC) drugs, or not to sell any injectable. And that said entity will not be used as a **clinic, treatment room,** or **otherwise**. Failure to comply, the Board shall **revoke** the license of the entity and the place be closed to the general public until otherwise order by the Pharmacy Board of Liberia.

Signed: _____ Date: _____

B. DISPENSER

1. Name of Dispenser _____ Sex (M), (F)
2. Address _____
3. Date of Birth _____ Place of Birth _____ County _____
4. Nationality _____
5. Did you attend High School? yes / No Name /Address of School _____
6. Highest grade completed _____ Certificate _____ Degree _____
7. Name of institution granting dispenser training _____
8. Year _____ Country/County _____
9. **Qualification of Dispenser:**
   a. Pharmacist _____ b. Physician _____ c. Dispenser _____ d. RN _____ e. Midwife_____
   f. Nurse Aide _____
10. Number of years worked in the distribution of medicine area or Pharmacy: _____
11. State working experience: **(Place of Work)**
    1. _____ Year _____
    2. _____ Year _____
13. **Photocopy of current license and 1 photo (to be attached) - if applicant is a licensed dispenser/pharmacy Technician**

I dispenser _____ of _____ entity do hereby vow that all information given above are true and will not use said medicine store as a **clinic, treatment room,** or sell any injectable items, also vow to sell only over the counter (OTC) drugs. Failure to comply, my license or permit shall be **revoked** by the Board.

_____
DISPENSER'S SIGNATURE

E-mail: pharmacyboardliberia@yahoo.com