



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



JANUARY – DECEMBER 2024
PLEASE TYPE ALL INFORMATION
RENEWAL FORM
Retail Pharmacy

County: _____ Code: _____

Name of Pharmacy: _____

***Please attach Photocopy of Business Registration, PBL Permit for 2023, and Photocopy of Dispenser ID Card & Pharmacist license for 2024**

*** Please attach Labor Work Permit 2023-2024 (NON – LIBERIAN ONLY)**

Location _____

Registration Year _____

Proprietor/Proprietress (1): _____ Contact: _____ Nationality: _____

Proprietor/Proprietress (2): _____ Contact: _____ Nationality: _____

Cashier / Manager _____ Contact: _____ Nationality: _____

County: _____

Dispenser/Pharm-Tech (1): _____ LPB#: _____ County: _____

Cell No _____ Date: _____

Dispenser/Pharm-Tech (2): _____ LPB#: _____ County: _____

Cell No _____ Date: _____

Email: _____

Pharmacist-in-charge Signature: _____ PBL#: _____

Cell No. _____ Email: _____

Note: No retail pharmacy shall operate as a clinic, treatment room, only registered pharmacist and dispenser are permitted to sell drug therein. Failure to comply, the Board shall **revoke** the permit of the pharmacy and the place be closed to the general public until otherwise ordered by the Pharmacy Board of Liberia.

Approved: _____ Date: _____
Pharmacist-In-Charge

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 POI
1000 MONROVIA- 10 LIBERIA
P.O. BOX 10-9009
WEST AFRICA



Our Ref. No. **PLEASE TYPE ALL INFORMATION**
JANUARY-DECEMBER 2024
PHARMACY STAFF (NON - LIBERIAN ONLY)

Name of Pharmacy: _____ Identification / Code: _____

Address: _____

I. D.
PHOTO

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

I. D.
PHOTO

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

I. D.
PHOTO

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

Approved: _____
Pharmacist-In-Charge

Date: _____