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

REGISTRATION FORM

Retail Pharmacy

County: _____ Code. _____

Name of Pharmacy: _____

*** Please attach Labor Work Permit (ONLY FOREIGNER) &Current License for Pharmacist 2023**

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: _____

Pharmacist -In-Charge: _____

PBL#: _____ Signature: _____

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 license of the entity 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 POINT
1000 MONROVIA- 10 LIBERIA
P.O. BOX 10-9009
WEST AFRICA

Our Ref. No.

PLEASE TYPE ALL INFORMATION

JANUARY-DECEMBER 2024

Name of Pharmacy: _____ Identification / Code: _____

Address: _____

I. D. PHOTO

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

I. D. PHOTO

Name: _____
Nationality: _____
Operation Title: _____
Telephone #s: _____
Holder's Signature: _____

I. D. PHOTO

Name: _____
Nationality: _____
Operation Title: _____
Telephone #s: _____
Holder's Signature: _____

Approved: _____ Date: _____
Pharmacist-In-charge

Email: pharmacyboardliberia@yahoo.com

PROPRIETORATE

1. Name of Proprietor/Proprietress(s)_____Nationality: _____

2. _____ Nationality: _____

Address:_____ Cell No.: _____

E-mail: _____

I _____, Proprietor of _____

Do hereby apply to the Board for the year _____ and hereby vow to serve as **proprietor** of said entity, and also vow that said entity will not be used as a **clinic, treatment room, wholesale facility, or sell any contraband / expired substances** 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 ordered by the Pharmacy Board of Liberia.

Signed: _____ Date: _____

3. All **Foreign businessmen or resident(s)** shall attach copy (ies) of their working permit from the Labor Ministry.

C. DISPENSER:

1. Name of Dispenser_____ Cell#: _____
2. Address _____
3. Date of Birth _____ Place of Birth _____ County/Country _____
4. Nationality _____
5. Have you completed High School? Yes☐ / No☐
6. Address of School _____ County: _____ Year: _____
7. Highest grade completed _____ Certificate _____ Degree _____
8. Date high school certificate was issued _____
9. Name of institution granting dispenser training _____
10. Year _____ Country/County _____
11. **Qualification of Dispenser:**

a. Registered Nurse _____ b. Practical Nurse _____ c. Physician Assistant _____

d. Pharmacy Technician _____ e. Dispenser_____ f. Midwife _____ g. NA _____

12. Number of years worked in the distribution of drugs _____
13. 14. State working experience: **(Place of work)**

1. _____ Year _____

2. _____ Year _____

15. **Photocopy of current license and 1 photo (to be attached), if applicant is a registered dispenser/pharmacy technician**

I dispenser_____ of _____ Pharmacy do hereby vow that all information given above are true and will not use said Pharmacy as a **clinic, treatment room**, or sell any contraband / expired substances. Failure to comply, my license or permit must be revoked by the Board.

_____ _____

DISPENSER'S SIGNATURE **DATE**

Approved: _____ _____

Pharmacist-In-Charge **DATE**

E-mail: pharmacyboardliberia@yahoo.com

D. PHARMACIST:

1. Name of Pharmacist_____ PBL#: _____ Sex (M), (F)

2. Address _____ Tel: _____

3. Place of Assignment: _____ Position _____ County/Country _____

4. Nationality _____

5. Address of Pharmacy training school attended: _____

_____

Year _____

6. B-Pharm _____ Pharm-D_____

7. is your association's dues paid? Yes ☐ /No ☐ if **YES**, please attach photocopy of present receipt.

8. Have you renewed your license with the Board? Yes ☐ / No ☐ if **YES**, please attach photocopy of your Present license.

I _____ Pharmacist of _____

Do hereby apply to the Pharmacy Board for renewal/registration for the year _____ and do vow that I will not use the pharmacy as a **clinic**, **treatment room**, or sell any contraband / expired substances. Failure to comply, the Board shall **revoke** my license to practice pharmacy.

_____ DATE: _____

Pharmacist-In-Charge

E-mail: pharmacyboardliberia@yahoo.com