



e-form

Application for a Pharmacy Licence for Medicinal Products for Human Use and/or authorisation



To complete this form kindly note that the below documents will be requested:

1. Declaration of Managing Pharmacist (refer to Annex B).
2. Police conduct of proposed license/ authorisation holder.
3. Site plan.
4. An exact total footprint (floor area) declaration endorsed by an architect for the pharmacy.

The premises plan and floor area declaration should cover all premises of the pharmacy including all areas used as clinics and any storage space connected with the pharmacy premises and thus covered by the proposed pharmacy licence.

5. Declaration from architect stating the exact distance measured as the shortest walking distance, from nearest other pharmacies in the same locality and neighboring localities.
6. Comprehensive description of the layout and operation of premises available for the storage and dispensing of medicinal products.
7. A proof of payment for the application form as established by S.L. 458.46 'Medicines Authority (fees) Regulations'.
8. Planning Authority permit of the premises.

If the applicant is a company:

9. Original Memorandum of Articles of company issued by MFSA.

SECTION A: GENERAL INFORMATION

1. DETAILS OF PROPOSED LICENCE/AUTHORISATION HOLDER

1a If Individual:

Name:

Surname:

ID or Passport
Number:

1b If company:

Name:

Company
registration
number:

Legal and judicial
representative of
company:

Name:

Surname:

ID or Passport No.:

2a LEGAL ADDRESS OF PROPOSED LICENCE/AUTHORISATION HOLDER

[If an individual, include the address on your ID card below. If a company, include the company address registered with MFSA below.]

Name/No.:

Street:

Locality:

Postcode:

Telephone number:

Mobile Number:

Email Address:

2b CONTACT ADDRESS FOR COMMUNICATION (if different from above)

Name/No.:

Street:

Locality:

Postcode:

SECTION B: SITE INFORMATION

3a Name of proposed
pharmacy/site (site name):

3b Site Address of proposed pharmacy/site

Name/No.:

Street:

Locality:

Postcode:

3c Additional site for storage

Name/No.:

Street:

Locality:

Postcode:

SECTION C: THE MANAGING PHARMACIST

5a Please give the following details of the person who is to carry out the function of Managing Pharmacist:

Name:

Surname:

Initials and
ID card number:

Pharmacy council
registration
number:

5b Contact Details

Telephone number:

Mobile number:

Email Address:

SECTION D

DECLARATION

I/We apply for the grant of a Pharmacy license/authorisation to the proposed holder named in this application form in respect of the activities to which the application refers, and undertake that:

1. The activities are to be only in accordance with the information set out in the application or furnished in connection with it.
2. As proposed license/authorisation holder, I am not a medical practitioner, dental surgeon or veterinary surgeon, nor do I have any business agreement with any of these professionals.
3. I am not in possession of another pharmacy licence.
4. To participate in any national pharmaceutical distribution or dispensing system that the Minister of Health may at any time wish to introduce.
5. The license/authorisation is to be subject to all the Standard Provisions applicable to Pharmacy licenses/authorisation under regulations for the time being in force and which may come into force from time to time.
6. I declare that the particulars and information I have given in this form are correct and complete.

Signature of proposed license/authorisation holder or legal representative in case of company:

Kindly fill in the Declaration form at the following link
<http://www.medicinesauthority.gov.mt/onlineapplications>
A Declaration form should be submitted for each signatory.

Date:

Name and
Surname:
(BLOCK LETTERS)

ANNEX A- DOCUMENTS TO BE ATTACHED WITH APPLICATION

1. Declaration of Managing Pharmacist (refer to Annex B).
2. Police conduct of proposed license/authorisation holder.
3. Site plan.
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ANNEX B- MANAGING PHARMACIST DECLARATION FORM

I,

Registration
number:

declare that I will be the Managing Pharmacist for:

Proposed pharmacy/site name:

Site Address of pharmacy

Street:

Locality:

Postcode:

I undertake to inform the Medicines Authority in writing of any replacement and/or locum pharmacists that may substitute me as the need arises. A signed declaration shall also be submitted when my duties at the above-mentioned pharmacy/authorisation are terminated.

Signature: Kindly fill in the Declaration form at the following link
<http://www.medicinesauthority.gov.mt/onlineapplications>
A Declaration form should be submitted for each signatory.

Date: