



MALTA

MEDICINES  
AUTHORITY

**PHY004-03 Appendix 2B v01**

Variation to a Pharmacy Licence/Authorisation - Change in Managing  
Pharmacist



e-form

## Variation to a Pharmacy Licence/Authorisation - Change in Managing Pharmacist



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

- *DDA stock-take for both Private and POYC signed by both the current and proposed Managing Pharmacist.*
- *CV of the Proposed Managing Pharmacist.*
- *Proof of Payment*

Please note that this application shall be signed using wet ink. Hard copies of the application and all other documents required for the completion of the form shall be sent by registered post to the Malta Medicines Authority, Life Sciences Park, San Gwann Malta. Kindly note that the application will be processed once all documentation is received in hard copy.

## Section A: Details of Present Licence Holder

### 1a. If Individual

Name

Surname

ID/Passport Number

Telephone Number

Mobile Number

Email Address

### 1b. If Company

Name

Company Registration  
Number

Legal and Judicial Representative of Company:

Name

Surname

ID/Passport Number

Telephone Number

Mobile Number

Email Address

## Section B: Details of Pharmacy Licence

**DL Number**

**Pharmacy Name**

**Street**

**Locality**

**Postcode**

**Telephone Number**

**Email**

### **Details of Current Managing Pharmacist**

**Name**

**Surname**

**Registration Number**

**Mobile Number**

**Email**

## Section C: Details of Proposed Managing Pharmacist

**Name**

**Surname**

**Registration Number**

**Mobile Number**

**Email**

**Are you already a Managing Pharmacist at another pharmacy?**

## Section D: Declarations

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### Declaration By Current Managing Pharmacist

As the managing pharmacist of the pharmacy outlined in section B, I confirm that I have informed the Malta Medicines Authority of my intention to step down as Managing Pharmacist of the above mentioned pharmacy.

Name and Surname

Registration Number

Signature

Date

### Declaration By Proposed Managing Pharmacist

I declare that I will act as Managing Pharmacist for the pharmacy mentioned in Section A of this application. 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 to the Medicines Authority when my duties at the above-mentioned pharmacy are terminated.

Name and Surname

Registration Number

Signature

Date

## Section D: Declarations

### Declaration By Current Licence Holder

I, the applicant declare that all information given in the application form is true, complete and correct. I also bind myself to inform immediately any change to details in the application form and annexes, where relevant, to the Malta Medicines Authority.

Name and Surname

Signature

Date