Director
Medical Supplies Division

# Pharmacy Registration Form

* **this field is required**

Pharmacy Type ◯ Whole Sale ◯ Retail

Pharmacy Name *

Expiration Date *

Company Name *

Business Registration Number *

Vat Registration Number

## Pharmacist Details

Pharmacist Name *

Pharmacist SLMC Reg No *

## Contact Details

Address *

Fax

Telephone *

Email *

I certify that the above details are true and correct on behalf of my knowledge.

……...
Signature of the head of institute

……...
Name and Designation
(With official stamp)

……...
Date