

## Local Manufacturer Supplier Registration Form

\* this field is required

Pharmacy Type	<input type="radio"/> Whole Sale	<input type="radio"/> Retail	
Pharmacy Name	<input type="text"/>		*
Expiration Date	<input type="text"/>		*
Company Name	<input type="text"/>		*
Business Registration Number	<input type="text"/>		*
Vat Registration Number	<input type="text"/>		

### Pharmacist Details

Pharmacist Name	<input type="text"/>	*
Pharmacist SLMC Reg No	<input type="text"/>	*

### Contact Details

Address	<input type="text"/>	*
Fax	<input type="text"/>	
Telephone	<input type="text"/>	*
Email	<input type="text"/>	*

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