1.0 POLICY BACKGROUND

Pharmaceutical service providers in Ghana consists mainly of pharmacists, pharmacy technicians and Over the Counter Medicine Sellers (OTCMS). However, in community pharmacies there are other staff other than pharmacists and pharmacy technicians termed as Medicine Counter Assistants (MCAs). Similarly, in OTCMS shops we have other staff designated as OTCMS Assistants. All these professionals and support staff provide some level of care depending on the category of the staff. Pharmaceutical service provider therefore must possess the relevant knowledge and skills in accordance with their roles. Hence pharmaceutical service providers should be able to apply their knowledge and skills on behalf of other members of the community to optimize health outcomes from medicines and minimize medication misadventure.

This commitment to act in the service of others comes along with an obligation to do so in accordance with set standards. It also carries with it a fundamental obligation to maintain professional competence and to practice within the agreed limits for pharmacists and each category of pharmacy support staff.

The concept of practitioner competence can only be nurtured through initiatives such as practitioner registration and competency-based trainings. The registration and licensing of professionals and their practice is therefore the bedrock of professional practice. This bring to the fore the recognition by professional peers and the general public of the suitability of the practice environment and expertise of each practitioner category.

Pharmacy practice and the premises where it is practiced in Ghana had been regulated under Pharmacy Act, 1994 (ACT 489) by the Pharmacy Council until 2011 when the Health Institutions and Facilities Act (ACT 829) was passed, mandating the Health Facilities Regulatory Agency (HeFRA) to, also license and monitor facilities for the provision of public and private health care services.

Subsequently, in 2013 the Health Professions Regulatory Bodies Act, (ACT 857) was passed to replace Pharmacy Act, 1994 (ACT 489) which has specific sections prescribing how practitioners, their practice and where they practice should be licensed as follows;
1. Section 93 of the Health Professions Regulatory Bodies Act, 2013 (ACT 857) provides for the licensing of corporate bodies.
2. Section 94 similarly provides for the licensing of Over The Counter Medicine Sellers,
3. Section 95 also provides for the licensing of wholesale supply of restricted medicines.

Clearly, the Pharmacy Council (PC) and Health Facilities Regulatory Agency (HeFRA) have overlapping roles and therefore require inter-agency collaboration to fashion out common pathways and strategies to efficiently register premises of pharmaceutical facilities to guarantee effective regulation of the sector in Ghana.

This policy document seeks to put together all the guidelines, procedures and processes required in the registration and licensing of practitioners, body corporates and government institutions who are involved in the business of mixing, compounding, preparing or supplying restricted medicines in Ghana.

1.1 Underpinning Philosophy and Legal Framework

Standards of pharmaceutical care must be linked to the roles and responsibilities of the people providing that care. Registered body corporates and pharmaceutical service providers therefore have a ‘duty of care’ over the health and safety of clients and members of the public whilst in their working environment. This will imply that any person involved in the provision of pharmaceutical care in pharmacies and OTCMS shops are registered and trained based on their respective roles to guarantee the health and safety of the general public in the discharge of their duties. The Pharmacy Council is mandated by section 79 of the Health Professions Regulatory Bodies Act 2013, Act 857 Part 4 to secure in the public interest the highest standards in the practice of pharmacy in Ghana. Specifically;
Section 80 (c): requires the Council to register practitioners.
Section 80(f): to set and ensure standards for pharmacy practice and professional conduct.
Section 80(g): to provide guidelines for the education, training, registration, licensing and the practice of all pharmaceutical support staff
The Pharmacy Council shall therefore adopt strategies and procedures to ensure the execution of the above mandate to guarantee quality and safe practice of pharmacy in Ghana.

This policy document is intended for all stakeholders. These include:

- Registered Pharmacists
- Registered pharmacy support staff
- Pharmaceutical Society of Ghana
- Recognized Association(s) of Pharmacy Support Staff
- Training Institutions for Pharmacists.
- Training Institutions for Pharmacy Support Staff.
- All institutions or firms where pharmacists are employed
- All institutions or firms where pharmacy support staff are employed
- Ministry of Health
- Ghana Health Service
- Food and Drugs Authority
- Ghana Standards Authority
- Health Facility Regulatory Agency
- The Pharmacy Council
- Media Agencies

1.2 Benefits to Practitioners
- Practitioners may be able to establish their proven knowledge, understanding and competence.
- It enhances practitioner recognition and satisfaction

1.3 Benefits to the Public
- Assures quality and safe practice of pharmacy by practitioners.
1.4 Benefits for employers

- Enhanced selection and recruitment of staff
- Ensure that practitioners engaged at all times offer the optimum care required by their respective levels of practice.
- Capacity development of staff can be more consistent and directed to improve delivery of roles and responsibilities of staff.

2.0 ENABLING LEGISLATION
The Council shall actively work for the enactment of the necessary legislative instruments to ensure that only;

- registered pharmacy support staff are permitted to work in pharmaceutical facilities.
- pharmacy support staff who have undergone prescribed training are permitted to work in pharmaceutical facilities.
- registered vehicles/cars are permitted to transport/deliver medicines in Ghana.

The proposed legislation shall provide for the procedures and guidelines in dealing with all registration related issues including the enforcement and sanctions for offending practitioners and pharmacy business entities.

3.0 SCOPE
This policy document covers the registration and licensing of both pharmacy businesses and practitioners.

4.0 BROAD OBJECTIVES AND STRATEGIES
1. To provide the framework for the registration of all pharmacy support staff.
2. To ensure that only registered pharmacists in good standing are allowed to superintend facilities or work as a pharmacist.
3. To ensure that only registered pharmacy support staff in good standing are allowed to work in pharmacies and OTCMS shops.
4. To provide a framework for the registration of pharmacies and OTCMS
5. To ensure consistency, transparency and accountability in the decision-making process relating to applications
6. To ensure that pharmacies and OTCMS are registered in accordance with the law and laid down procedures
7. To ensure equitable and accessible distribution of pharmaceutical premises.
8. Provide a framework for addressing the grievance of stakeholders.

5.0 PRE-REGISTRATION INTERNSHIP FOR PRACTITIONERS

The goal of the internship programme
To provide a means of building up for the future competent pharmacists and pharmacy support staff who provide quality pharmaceutical care.

Objectives
- To train intern pharmacists and pharmacy support staff for careers in pharmaceutical services.
- To equip and improve the professional skills of the intern.
- To provide an understanding of the role of the pharmacists and pharmacy support staff in the health care team.
- To foster widespread and thorough understanding of the mandate of the pharmacist and pharmacy support staff to the public he/she serves.
- To understand the scope of pharmacy practice in Ghana through practical exposure.
- To provide practice-based educational programme for improving quality assurance methods that pharmacists and pharmacy support staff apply to their work.
- To provide understanding of the ethical, legal and regulatory principles that affects the pharmacy profession and practice.

The Pharmacy Council therefore considers applications from both local and foreign trained pharmacy graduates and foreign practicing pharmacists who wish to practice pharmacy in Ghana and shall determine whether applicants are eligible for internship or not.
To be eligible for pharmacy internship, applicant must have completed a pharmacy degree programme that is registrable in the country of training as a pharmacist or hold a qualification recognised by the Board that entitles that person to be registered as a pharmacist. Similarly, to be eligible for Pharmacy Technician Internship in Ghana, applicant must have completed a Higher National Diploma in Dispensing Technology or hold a qualification recognised by the Board that entitles that person to be registered as a Pharmacy Technician. In accordance with Sections 84 and 157 of the Health Professions Regulatory Bodies Act, 2013 (ACT 857), a non-citizen who intends to practice in Ghana shall in addition to satisfying other parts of the law must hold a valid work permit or otherwise be entitled to work in gainful employment in the country.

All documents must be supported by a statutory declaration to the effect that they are genuine and relate to the applicant. If the original documents submitted by the applicant in not in English, applicant must be made to submit an English version of all documents duly certified.

**Locally trained pharmacy-graduate applicants**
- A completed Pharmacy Internship application form.
- A certified true copy of your degree certificate.
- Proof of citizenship (i.e. Copy of Passport page)
- A copy of your work permit in your passport (for non-Ghanaian applicants)
- A recent passport size photograph.
- A non-refundable internship processing fee determined by the Governing Board.

**Foreign trained pharmacy-graduate applicants**
- An application letter for the internship programme.
- A completed copy of the Pharmacy Council's application form.
- A certified true copy of your degree certificate.
- A transcript from your training institutions posted directly by the institution to the Registrar of the Council.
- Proof of citizenship (i.e. Copy of Passport page)
- A copy of your work permit in your passport. (for non-Ghanaian applicants)
• A recent passport size photograph.
• A non-refundable internship processing fee determined by the Governing Board.

Foreign practicing pharmacist applicants
• An application to the Registrar for the internship.
• A completed, signed and dated copy of Council’s application form.
• Certified true copy of your Pharmacy degree certificate.
• A transcript from your training institution posted directly by the institution to the Registrar of the Council.
• Reference letter from your current employer posted directly by your employer to the Registrar of the Pharmacy Council.
• Confirmation of your licensure by the registration authority or body that grants you the license to practice as a pharmacist in that country posted directly to the Registrar of the Pharmacy Council.
• A copy of your current resume with dates and evidence of not less than two (2) years practice experience as a pharmacist.
• Proof of citizenship (i.e. Certified copy of your passport)
• A copy of your work permit in your passport. (Non-Ghanaian applicants only)
• A recent passport size photograph.
• A non-refundable internship processing fee to be paid after your documentation is accepted by the Council through an official letter issued to you.

Locally trained HND Dispensing Technology-graduate applicants
• A completed experiential training application form.
• A certified true copy of your degree certificate.
• Proof of citizenship (Birth certificate, Passport)
• A copy of your work permit in your passport. (for non-Ghanaian applicants)
• A recent passport size photograph.
• A non-refundable experiential training processing fee determined by the Governing Board.

6.0 PRACTITIONER REGISTRATION
In the context of this policy, a practitioner refers to a pharmacist, pharmacy technician, Over The Counter Medicine Seller (OTCMS) or Medicine Counter Assistant (MCA). All practitioners are supposed to undergo mandatory academic and professional/experiential training over different durations and be examined before successful candidates become eligible for registration. Pharmacy graduates undergo 4-6 years academic programme plus 1year internship. Pharmacy technician graduates do 3years academic programme plus 1year experiential, MCAs do 3months academic plus 3months experiential whilst OTCMS applicants who currently undertake a day orientation shall be made to undertake some 3 months training before they become eligible for registration.

6.1 Conditions for registration of pharmacists
A person shall not be registered to practice as a pharmacist unless that person
(a) holds a degree in pharmacy
(b) holds a qualification recognized by the Board that entitles that person to be registered as a pharmacist, and
(c) provides evidence of completion of a pharmacy internship programme in Ghana undertaken in an accredited pharmacy institution after academic training.
(d) has proof of qualification and registration to practise in that country where that person was trained (foreign trained applicants only).
(e) has passed the professional qualifying examination, and
(f) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.

(g) Provides evidence of membership with a recognized professional association in Ghana.

(h) Pay the prescribed fee.

6.2 **Conditions for registration of additional qualifications of pharmacists**

A pharmacist who has obtained a higher degree or additional qualification is entitled to have the higher degree or additional qualification inserted in the register of pharmacists in addition to the qualification previously registered.

To be eligible to apply, you must have completed a relevant post graduate programme or any other course that is relevant to the practice of Pharmacy in Ghana. The applicant must be a registered pharmacist in Ghana and has practice for a minimum of three years in Ghana.

A pharmacist may be required to satisfy all of the following to be eligible for registration of additional qualification in Ghana.

1. Letter of intent
2. A certified copy of the additional qualification certificate
3. A transcript from the issuing University
4. Attestation letter from the Ghana College of Pharmacists
5. Catalogue of relevant scientific papers published including papers related to the certificate you are seeking to register.
6. Resume of applicant
7. Proof of citizenship (i.e. Passport)
8. A copy of your work permit in your passport. (for non-Ghanaian applicants)
9. Evidence of payment of a prescribed processing fees
6.3 **Conditions for registration of pharmaceutical support staff**

A person shall not be registered to practice as a pharmaceutical support staff unless that person fulfils the requirements determined by the Governing Board of the Pharmacy Council.

6.3.1 **Pharmacy Technicians**

A person shall not be registered to practice as a pharmacy technician unless that person

(a) holds a Higher National Diploma in Dispensing Technology

(b) holds a qualification recognized by the Board that entitles that person to be registered as a pharmacy technician, and

(c) provides evidence of completion of a supervised practical training undertaken in an accredited pharmacy institution after academic training in the country.

(d) has passed the Ghana Pharmacy Technician Qualifying Examination,

(e) Provides evidence of membership with a recognized professional association in Ghana.

(f) satisfies any other requirements of ACT 857 Part IV.

(g) Pay the prescribed fee.

6.3.2 **Medicine Counter Assistants (MCAs)**

A person shall not be certified as an MCA unless that person

(a) holds a minimum of an SSCE/WASSCE certificate

(b) provides evidence of completion of a six-month prescribed training in an accredited institution in Ghana

(c) has passed the MCA Certification Examination conducted by the Pharmacy Council,

(d) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.

(e) Pay the prescribed fee.
6.3.3 Over The Counter Medicine Sellers (OTCMS)

A person shall not be registered to practice as an OTCMS unless that person

(a) holds a minimum of an SSSCE/WASSCE certificate
(b) has passed the Ghana OTCMS Qualifying Examination conducted by the Pharmacy Council
(c) provides evidence of participation in a pre-licensing training organised by the Pharmacy Council after the examination.
(d) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.
(e) Pay the prescribed fee.

6.3.4 OTCMS Assistants

A person shall not be certified as OTCMS assistant unless that person

(a) holds a minimum of an SSSCE/WASSCE certificate
(b) provides evidence of participation in a prescribed training programme organised by an accredited training institutions in Ghana.
(c) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.
(d) Pay the prescribed fee.

7.0 CONDITIONS FOR RENEWAL OF PRACTITIONER’S REGISTRATION

7.1 Renewal of registration as a pharmacist

The registration of a pharmacist elapses at the end of each year. It is the responsibility of the pharmacist to renew his/her registration before the end of the year to maintained his/her name on the register of pharmacists.

This renewal shall be done over the last month of every year. The list of all registered pharmacists who have renewed their licensure will be published in the gazette by 31st January. Pharmacists who do not renew their licensure will be deemed as not in good standing and therefore cannot practice.
(a) Completes the prescribed renewal form
(b) provides evidence of attainment of a minimum of ten (10) Continuing Professional Development (CPD) credits in the previous year.
(c) Provides evidence of good standing with a recognised professional association in Ghana.
(d) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.
(e) Pay the prescribed fee.

7.2 Renewal of registration as a Pharmacy Technician

The registration of a pharmacy technician elapses at the end of each year. It is the responsibility of the pharmacy technician to renew his/her registration before the end of the year to maintain his/her name on the register of pharmacy technicians.

This renewal shall be done over the last month of every year. The list of all registered pharmacy technicians who have renewed their licensure will be published in the gazette by 31st January. Pharmacy technicians who do not renew their licensure will be deemed as not in good standing and therefore cannot practice.

A pharmacy technician’s registration shall not be renewed unless that practitioner
(a) Completes the prescribed renewal form
(b) provides evidence of attainment of the prescribed minimum Continuing Professional Development (CPD) credits in the previous year.
(c) Provides evidence of good standing with a recognised professional association in Ghana.
(d) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.
(e) Pay the prescribed fee.
7.3 **Renewal of registration as a Medicine Counter Assistant**

The registration of a medicine counter assistant elapses at the end of every three (3) years. It is the responsibility of the MCA to renew his/her registration before the end of the third year to maintained his/her name on the register of MCAs.

Medicine counter assistants who do not renew their certification will be deemed as not in good standing and therefore cannot practice.

An MCA’s certification shall not be renewed unless that support staff

(a) Completes the prescribed renewal form

(b) provides evidence of participation in prescribed refresher training programmes for MCAs over the three-year period.

(c) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.

(d) Pay the prescribed fee.

7.4 **Renewal of registration as an Over The Counter Medicine Seller**

The registration of an OTCMS elapses at the end of every year. It is the responsibility of the OTCMS to renew his/her registration before 31st January each year to maintained his/her name on the register of OTCMs.

OTCMS who do not renew their registration will be deemed as not in good standing and therefore cannot practice.

An OTCMS’s registration shall not be renewed unless that practitioner

(a) Completes the prescribed renewal form

(b) provides evidence of participation in prescribed refresher training programme(s) for OTCMS in the previous year.

(c) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.

(d) Pay the prescribed fee.
7.5 **Renewal of registration as an Over The Counter Medicine Sellers Assistant**

The certification of an OTCMS assistant elapses at the end of every three (3) years. It is the responsibility of the OTCMS assistant to renew his/her certification before the end of the third year to maintained his/her name on the register of OTCMS assistants.

OTCMS assistants who do not renew their certification will be deemed as not in good standing and therefore cannot practice.

An OTCMS assistant's certification shall not be renewed unless that support staff

(a) Completes the prescribed renewal form

(b) provides evidence of participation in prescribed refresher training programmes for OTCMS assistants over the three-year period.

(c) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.

(d) Pay the prescribed fee.

8.0 **FITNESS TO PRACTICE**

The Pharmacy Council regulates the practice of pharmacy by pharmacists and pharmacy support staff in Ghana. We keep a register of all practising pharmacist and pharmacy support staff in Ghana. It is illegal to work as a pharmacist or pharmacy support staff without being on the register of the Pharmacy Council. There shall be clear procedures for taking action when there are concerns about a pharmacy intern, pharmacist, or pharmacy support staff's fitness to practise safely and effectively.

The main objective of this guidelines is to safeguard the health and well being of persons using or needing the services of pharmacists or pharmacy support staff. The enabling legislation governing practitioners fitness to practise procedures shall be set out in the Pharmacy Council fitness to practise legislative instrument to be passed soon.
9.0 TRANSPORTATION AND HANDLING OF MEDICINES

Even though medicines are used to cure, manage and prevent diseases, they are also potentially dangerous if used or handled improperly. The handling and use of medicines should therefore be guided by appropriate policies and programmes to ensure safe and secure handling of medicines. This is necessary to ensure:

a) patient safety.
b) the quality and efficacy of medicines throughout its storage, handling and use.
c) proper accountability for medicines management and administration.

The general principles associated with the safe and secure handling of medicines commonly referred to as the 3Rs relates to: Responsibility, Record-keeping, and Reconciliation. These form the framework of the ‘medicine audit trail’.
The Pharmacy Council shall establish, document and maintain an effective and economically viable system to ensure that medicines are procured, stored, handled, prescribed, dispensed and administered in a safe and secure manner.
At each step where medicines change hands, there shall be clearly laid-down procedures to clarify:

(i) Responsibility - person(s) responsible, whether it may be delegated, and how far the delegation extends.
(ii) Record-keeping - what should be recorded, where, by whom, and for how long records should be kept.
(iii) Reconciliation - who should do it and how often it should be done

10.0 REGISTRATION OF VEHICLE(S) FOR THE DELIVERY OF MEDICINES

The pharmacist or body corporate making the supply shall ensure that the driver and or person(s) transporting the medicines are registered with valid operational permits before they can be engaged to transport medicines. Additionally, the vehicle(s) used by wholesale pharmaceutical company must be registered with the Pharmacy Council. The person(s) transporting the medicines shall be responsible for the security of the medicines until delivery acknowledged.
11.0 VARYING OF SUPPORT STAFF WORKPLACE DETAILS
Where a change occurs in the workplace details of a support staff, the Pharmacy Council shall be notified in writing indicating his/her previous and the new workplace details and the reasons for the change. In addition, the applicant shall pay the prescribed fee. The Council shall update its records accordingly. It is therefore an offence for both the employer and the practitioner to engage/work in a facility without registration of the support staff to that facility with the Pharmacy Council.

Variation of support staff workplace details can be done on-line at the Pharmacy Council website www.pcghan.org.

12.0 CHANGE OF NAME OF A REGISTERED PRACTITIONER
Where a change occurs in the name of a practitioner, the Pharmacy Council shall be notified of the new name indicating the changes on a prescribed form. This notification shall be supported with a copy of the gazette publishing such name change.

The applicant shall pay the prescribed fee after which the Council shall update its records accordingly and notify the applicant before the practitioner can use the said name.

13.0 PHARMACY BUSINESS REGISTRATION
13.1 Operational Framework
There is established, a Pharmaceutical Facilities Technical Committee (PFTC) in accordance with the provisions of the ACT 857.

The goal of such an administrative technical committee is to process all OTCMS, community and hospital pharmacy applications and make recommendations on the eligibility and suitability of same in accordance with set criteria to the Registrar.

The committee is charged with the following responsibility;
13.2 **Specific Objectives**

1. Consider all applications for establishing community pharmacies, hospital pharmacies and Over the Counter Medicines Sellers (OTCMS) shops. In the case of OTCMS the committee shall refer eligible applicants to undertake a written examination conducted by the Education, Training and Research Department in collaboration with the Registration & Licensing Department.

2. Ensure that the applications meet the set application criteria by the Council,

3. Ensure fairness and good governance practices on all applications brought before it.

4. Make a recommendation on the eligibility and suitability of the applications to the Registrar.

5. Submit detailed report on all applications considered, to the Registrar.

13.3 **Membership**

The members of the Committee shall consist of the following;

1. Dr. George Asumeng Koffour
   - Senior Lecturer, FPPS-KNUST

2. Mr Silas Agyekum
   - Practising Pharmacist

3. The Deputy Registrars
   - Pharmacy Council

4. Heads of Departments - (R&L, ETR, ROC, MIS/PI, LQA and EIG)

The committee may be provided administrative support by staff appointed by the Registrar.

13.4 **The role of the Chairman to the PFTC**

The Chairman of the Committee in consultation with the Registrar or his delegated officer shall;

1. Schedule meetings with agenda and cause committee members to be notified,
2. Invite committee members to attend meetings when required by the committee.
3. Preside, facilitate and guide the meeting according to the agenda and time available.
4. Ensure that all discussion items end with a decision, action or definite outcome.
5. Review and endorse the draft minutes before distribution to members.

13.5 Meetings of the Committee
The Pharmaceutical Facilities Technical Committee shall meet monthly. These meetings shall be scheduled within the last week of the months or the first week of the ensuing month.

13.6 Term of Office
The tenure of office of the Committee members shall be four years and eligible to be re-appointed for another term only, except the ex-officio members (The Deputy Registrar(s) and the Department Heads).

14.0 NEW PHARMACY BUSINESS APPLICATIONS
All applications for pharmacies and OTCMS businesses shall be made through the Regional Offices of the Pharmacy Council. Upon receipt of the application an authorised officer of the Pharmacy Council shall evaluate the application and ensure that all relevant information and documents are provided.

The following information shall be vetted among others for a pharmacy application:

i. The name of the company (Proposed name may be rejected if it sounds the same as an existing registered body corporate or connotes an illegal or prohibited practice or item)

ii. The name(s) and contact details of directors and shareholders (address, telephone numbers, fax, email)
iii. Details of the exact location of the premises, including the postcode, house number, street name, suburb/community, of the proposed location.

iv. The district within which the premise is located

v. The distance between the proposed pharmacy and the existing pharmacy facility closest to the proposed location.

vi. The services to be rendered from the proposed pharmacy.

Upon successful submission of the OTCMS/Pharmacy business application, the applicant shall receive a text message from the Pharmacy Council within 72 hours indicating a proposed inspection date(s). The Regional Manager shall ensure that the proposed site is inspected within 1 month. After the site inspection, the applicant shall receive a second message confirming the site inspection and give a provisional 3-month period within which the applicant must receive a decision from the Council in connection with the application. The Regional Manager shall ensure that his/her report on the application shall be forwarded to the Registration & Licensing Department of the Council within 7 working days after the site inspection has been conducted and acknowledged.

If the application is considered by the Pharmacy Council, the applicant shall be duly notified in writing within 10 working days.

15.0 RENEWAL APPLICATIONS
The Pharmacy Business Operating Permits and OTCMS Business Operating Permits shall be renewed annually and this shall be made before 31st January every year.

A Pharmacy Business Operating Permits and OTCMS Business Operating Permits shall not be renewed unless that applicant

(a) Completes the prescribed renewal form
(b) Submits the previous licence issued to the applicant by the Pharmacy Council

c) provides evidence of the superintendent pharmacists satisfying the prescribed minimum CPD credits (Pharmacies only)

(d) provides evidence of participation in prescribed refresher training programme(s) for all staff including the licensed practitioner (OTCMS shops only).

(e) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.

(f) Pay the prescribed fee.

16.0 CONDITIONS FOR VARYING PHARMACY BUSINESS OPERATING PERMIT

16.1 Change of Ownership

Where a change occurs in ownership of a pharmacy, the Pharmacy Council shall be notified in writing by the previous owners introducing the new owner(s) and a commitment to transfer all interest in the business to the new owners.

The ownership of a pharmacy business shall not be changed by the Pharmacy Council unless that applicant

(a) Completes the prescribed varying form

(b) Provides a deed of transfer/legal documents covering the transfer executed by a registered and practising lawyer where necessary.

(c) Provides Registrar Generals’ documents of the new owners

(d) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.

(e) Pay the prescribed fee.
16.2 Change of Business Name
Where a change occurs in the name of a pharmacy, the Pharmacy Council shall be notified of the new name. This notification must be supported with the relevant Registrar Generals’ documents.

The name of a pharmacy business shall not be changed by the Pharmacy Council unless that applicant

(a) Completes the prescribed varying form
(b) Provides the relevant Registrar Generals’ documents covering the change of name.
(c) Provides a deed of transfer/legal documents covering the transfer executed by a registered and practising lawyer where necessary.
(d) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.
(e) Pay the prescribed fee.

16.3 Change of Pharmacist
Where a change occurs in the superintendent pharmacist of a pharmacy, the Pharmacy Council shall be notified of the new superintendent pharmacist.

The superintendent pharmacist of a pharmacy business shall not be changed by the Pharmacy Council unless that applicant

(a) Completes the prescribed varying form
(b) Provides a resignation letter from the previous Superintendent Pharmacist or notice of termination of appointment of the Superintendent Pharmacist whichever is applicable
(c) satisfies any other requirements of the Health Professions Regulatory Bodies Act 2013, ACT 857 Part IV.
(e) Pay the prescribed fee.
16.4 Change of Location
The location of a pharmacy business shall not be changed by the Pharmacy Council unless that applicant;

(a) Completes the prescribed varying form
(b) Provides a written explanation of the reason for the relocation
(c) satisfies any other requirements of the Health Professions Regulatory Bodies Act, 2013, ACT 857 Part IV.
(d) Pay the prescribed fee.

The requirements for a change of location for pharmacies or OTCMS shops shall be the same as that for new pharmacy/OTCMS shop applications.

17.0 CONDITIONS AND PROCEDURE FOR SUSPENSION OF BUSINESS
Any pharmacy or OTCMS shop that suspends business shall accordingly notify the Council in writing giving a set time frame when the premises shall be closed to the general public but such suspension period shall not exceed one calendar year. The Council through its regional offices shall ensure that the pharmacy or OTCMS shop remains closed during the suspension period. The pharmacy or OTCMS shall notify the Council in writing on their intentions before the suspension period ends. There shall be a mandatory final inspection before the pharmacy/OTCMS shop can resume work.

18.0 CONDITIONS FOR THE ISSUE OF PHARMACY BUSINESS OPERATING PERMITS
There shall be a mandatory final inspection for all approved applications upon receipt of the applicant's request to do same.

In the case of OTCMS, the applicant shall attend a mandatory pre-licensing training before his/her final inspection shall be conducted.

The following conditions must also be satisfied by all body corporates, institutions and OTCMS applicants before their respective licences shall be issued.

1. Evidence of satisfying all approval letter conditions
2. Evidence of registration of all staff including drivers where applicable.
3. Evidence of registration of vehicle(s) to be used in delivering medicines (For wholesale pharmacy only)
4. Mandatory signboard for all OTCMS shops
5. Pharmacies and OTCMS shops must have appropriate layout
6. Mandatory wearing of lab coat and an accredited name tag for all staff

19.0 EQUITABLE AND ACCESSIBLE DISTRIBUTION OF PHARMACEUTICAL PREMISES AND PERSONNEL

There are a number of reasons why people living in Ghana may be denied access to pharmaceutical care. Key amongst which is the inadequate geographical coverage of pharmaceutical facilities (Pharmacies and OTCMS shops) and trained personnel (Pharmacists, Pharmacy Technicians, MCAs OTCMS and OTCMS assistants) to stock and dispense medicines in adequate conditions. Since 1995, the Pharmacy Council has been employing the distance criteria to influence equitable distribution of pharmaceutical facilities. Despite the Council’s efforts in this direction, about 80 – 85 % of pharmacies are located in the Greater Accra and Ashanti Regions, leaving the other eight regions in the country with 15 – 20%. Also, most of these pharmacies are located in the regional capitals, resulting in most districts in the country having no pharmacies at all.

This has serious implications for pharmacy practice and with the strategic direction of the Governing Council to transform pharmaceutical service delivery throughout the entire nation, the Council shall adopt policies and programmes that can accelerate the realization of its vision.

It is against this background that the Pharmacy Council is considering possible ways of getting pharmacies and the requisite personnel into the districts. Every District Assembly without a pharmacy shall be encouraged to partner the private sector to establish a pharmacy within that district. In addition, the Pharmacy Council shall collaborate with relevant state agencies to train adequate skill mix of pharmacy support staff to assist the pharmacist in the effective and efficient delivery of pharmaceutical care in Ghana.
20.0 RIGHT OF APPEAL AND GRIEVANCE REPORTING

The Pharmacy Council as a regulator is accountable to the public for its actions. In this regard, this policy provides the framework for reporting grievances relating to registration and licensing of pharmacists, pharmacy support staff, pharmacies and OTCMS shops.

An applicant who is not satisfied with a decision of the Council may appeal within 30 days from the date when notice of the decision in writing was sent to him or her. The appeal shall be in writing, stating in full the decision one is appealing against and the grounds for the appeal. The notice of appeal shall be addressed to the Registrar.

The Registrar shall within five (5) working days of receipt of the appeal acknowledge receipt in writing. The Registrar may refer an appeal to the Governing Board for a final decision.

21.0 DESIRED POLICY OUTCOMES

The success of this registration and licensing policy shall be measured in terms of the desired outcomes. The desired outcomes of this policy are as follows;

1. Improve patient safety and the quality of life of all people living in Ghana.
2. A better management of risks associated with pharmaceutical service delivery.
3. Increased satisfaction of the general public with the pharmaceutical service delivery in Ghana.
4. Increased job satisfaction of pharmacists and pharmacy support staff.
5. Improve the utilisation of resources in line with the expectations of the Ministry of Health.
6. Reduce inequalities in access to pharmaceutical service delivery.
22.0 POLICY REVIEW
This policy shall be continuously monitored by collecting and analyzing information on measurable indicators and comparing actual results to expected results in order to measure how well the policy is being implemented. The Pharmacy Council shall not only be concerned with taking the actions we agreed to take but also, achieving the results we set for ourselves. The entire policy implementation shall focus on results related to inputs, process, outputs and outcomes, and how they affect pharmaceutical service delivery.
This policy shall be reviewed annually. The review process may include an examination of the performance indicators and consultation with stakeholders. The Pharmacy Council reserves the right to review this policy document without prior notice to the public.
23.0 APPENDIX

Key Application Forms used in Registration and Licensing

23.1 Application form for pharmacy internship programme
23.2 Application forms for experiential training of HND Dispensing Technology graduates
23.3 Application forms for the registration of GPPQE
23.4 Application forms for the registration of newly qualified pharmacists
23.5 Application forms for the registration of additional qualifications of pharmacists
23.6 Application forms for the registration of pharmacy technicians
23.7 Application forms for the registration of pharmacy business
23.8 Application forms for the registration of OTCMS shop
23.9 Application forms for the registration of pharmaceutical support staff
23.10 Application forms for the registration of OTCMS
23.11 Application forms for the registration of OTCMS assistants
23.12 Application forms for the renewal of pharmacist's licensure
23.13 Application forms for the renewal of pharmacy technician's licensure
23.14 Application forms for varying pharmacy support staff workplace details
23.15 Application forms for the varying of pharmacy business operating permit
23.16 Application forms for the varying of OTCMS business operating permit
23.17 Application forms for the renewal of pharmacy business operating permit
23.18 Application forms for the renewal of OTCMS business operating permit
PHARMACY COUNCIL, GHANA
APPLICATION FOR PHARMACY INTERNSHIP TRAINING

1. Name................................................................. (Surname) (Other names)

2. Status:  [ ] Fresh graduate  [ ] Foreign Practicing P’cist  [ ] Newly Registered P’cist

3. NSS Number ................................................................................................................. (Where applicable)

4. Date of Birth ................................................................................ Place of Birth ...................................................... (dd/mm/yyyy) (City/Town, Country)

5. Nationality....................................................................................................................

6. **Contact Address:**
   Residential Address:
   Email:
   Phone Number:
   GPS Code:

7. Place of Residence in Ghana .................................................................

8. Pharmacy Institution attended .................................................................

9. Year of Entry......................................................................................

10. Year of Graduation.................................

11. Qualification obtained .................................................................................. Date: ......................... (mm/yyyy)

12. Introductory Pharmacy Practice Experience (IPPE) you have undergone:

<table>
<thead>
<tr>
<th>Institution</th>
<th>Job Description</th>
<th>Duration</th>
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<tbody>
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</tbody>
</table>
13. Advanced Pharmacy Practice Experience (APPE) you have undergone. (where applicable)

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<thead>
<tr>
<th>Institution</th>
<th>Job Description</th>
<th>Duration</th>
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</tbody>
</table>

14. INTERNSHIP PROGRAMME:

A. **HOSPITAL PHARMACY PRACTICE / OTHER INSTITUTIONS (Phase 1)**

Indicate in order of preference proposed region, district and institution for the internship

<table>
<thead>
<tr>
<th>REGION</th>
<th>DISTRICT</th>
<th>PROPOSED INSTITUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1\textsuperscript{st} choice</td>
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<tr>
<td>2\textsuperscript{nd} choice</td>
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</table>

B. **COMMUNITY PHARMACY PRACTICE (Phase 2)**

Indicate in order of preference proposed facilities for the community pharmacy practice experience

1\textsuperscript{st} Choice: .......................................................... .................................
2\textsuperscript{nd} Choice: .......................................................... .................................

(Note: The Pharmacy Council cannot guarantee that applicants will be posted to institutions of their choice.)

15. Were you sponsored by any government institution or mission? If yes, indicate the following:

   Name of Institution .......................................................... .............................................
   Location ..............................................................................................................................

16. Have you done National Service before? If yes, provide the following details:

   (For nationals only)
   Year.......................................................... Status..........................................................

17. Attach certified copies of academic certificates and evidence of nationality.

   Signature of applicant .......................................................... Date .......................................
PHARMACY TECHNICIAN EXPERIENTIAL TRAINING APPLICATION FORM

1. Name............................................................................................................................... (Surname) (Other names)

2. Date of Birth.............................................. 3. Place of Birth.................................
   (dd/mm/yyyy) (Town, Country)

4. NSS No. .................................................. Nationality.................................

5. Permanent Address: ....................................................................................

6. Contact address if different from 5

7. Tel. Res.................................................. Tel. Cellular ................................................

8. E-mail address ...........................................................................................................

9. Place of Registration in Ghana..................................................................................

10. Pharmacy Technician Institution(s) attended..........................................................

11. From .................................................. To:..................................................
    (mm/yyyy) (mm/yyyy)

12. Qualification and Date obtained .............................................................................
    (mm/yyyy)

13. List in Chronological order any vacation training you have undergone.

<table>
<thead>
<tr>
<th>Institution</th>
<th>Job Description</th>
<th>From (mm/yyyy)</th>
<th>To (mm/yyyy)</th>
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</tbody>
</table>
14. SITES FOR EXPERIENTIAL TRAINING PROGRAMME:

**HOSPITAL / OTHER INSTITUTIONS**
Indicate in order of preference proposed region, district and institution for the internship

<table>
<thead>
<tr>
<th>REGION</th>
<th>DISTRICT</th>
<th>PROPOSED INSTITUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1&quot; choice</td>
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</tr>
<tr>
<td>2&quot; choice</td>
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</tr>
<tr>
<td>3&quot; choice</td>
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</tbody>
</table>

**NOTE:** The Pharmacy Council cannot guarantee that all applicants for the experiential training will be posted to institutions of their first choice.

Signature of applicant........................................Date........................................

**PLEASE ATTACH CERTIFIED COPIES OF ACADEMIC CERTIFICATES.**

---

**FOR OFFICIAL USE ONLY**

Applicant posted to: Hospital ☐ Other Institution ☐

Name of Hospital:..................................................From........To............

Other Institution:..................................................From........To............

Signature of Officer..............................................................................
23.3

GHANA PHARMACY PROFESSIONAL QUALIFYING EXAMINATION
REGISTRATION FORM

Please complete this form in BLOCK LETTERS. After fulfilling all the requirements, return the
form including all the required documents to the Head Office or any of the Pharmacy Council
Regional /Zonal Offices. Fees paid cannot be transferred to any other examination session.
Affix a recently taken passport size photograph.

I wish to apply for the Pharmacy Professional Qualifying Examination scheduled for

…………………………………………………………… (Date)

PERSONAL INFORMATION

Name ....................................................................................... (Surname/Family name) (First/Given name) (Middle name)

Date of Birth ........................................................................... (dd-mm-yyyy)

Gender: Male ☐ Female ☐ (Check the appropriate one)

Nationality………………………………………………………….. Place of Birth………………………………………..

Marital Status: Single ☐ Married ☐ (Check the appropriate one)

Permanent Address................................................................

..................................................................................................Tel........................................

OTHER INFORMATION
University /College attended....................................................... 

Places of Internship training:

..................................................................................................

..................................................................................................

I acknowledge that the information provided is true and accurate.

Signature of applicant…………………………………..Date………………

FOR OFFICIAL USE ONLY

AMOUNT PAID……………………………………………………………..

OFFICIAL RECEIPT NUMBER………………………………………………..

DATE………………….. SIGNATURE………………………………
THE HEALTH PROFESSIONS REGULATORY BODIES ACT, 2013 (ACT 857) SECTIONS 82 - 84

APPLICATION FOR REGISTRATION AS A PHARMACIST

THE REGISTRAR
PHARMACY COUNCIL
P. O. BOX AN 10344, ACCRA-NORTH

I ........................................................................ (SURNAME) ......................................................................................... (FIRST NAME) ......................................................................................... (OTHERS)
of.................................................................................................................................................................................................

.................................................................................................................. (PERMANENT POSTAL ADDRESS)

Hereby make application for registration as a Pharmacist. My qualifications(s) are

........................................................................................................................................................................................................

I enclose registration fee of GHC ........................................................................................................................................

Signature: ......................................................................................

Date: ......................................................................................

FOR OFFICIAL USE ONLY

Pharmacy Council Receipt No. ........................................ Amount Paid: GHC ........................................

Pharmacist Registration No.: ........................................ Date: ......................................................................................
<table>
<thead>
<tr>
<th>RESIDENTIAL/PERSONAL</th>
<th>OFFICE (B)</th>
<th>TERTIARY EDUCATION</th>
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<tr>
<td>INSTITUTION OF TRAINING</td>
<td>PROGRAMME DURATION</td>
<td>QUALIFICATION OBTAINED</td>
</tr>
<tr>
<td></td>
<td>FROM</td>
<td>TO</td>
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<td></td>
<td>MONTH</td>
<td>YEAR</td>
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</table>

(C) INTERNSHIP

<table>
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<tr>
<th>INSTITUTION</th>
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<tbody>
<tr>
<td>FROM</td>
</tr>
<tr>
<td>MONTH</td>
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</tbody>
</table>

SIGNATURE: ____________________________  DATE: ____________________________
# GHANA

## REGISTERED PHARMACIST PERSONAL INFORMATION

**PHARMACIST**

**REGISTRATION NUMBER**

**Passport-sized photograph**

### (A) PERSONAL DETAILS

**TITLE**

(Miss, Mr., Mrs., Dr., Prof.)

<table>
<thead>
<tr>
<th>I</th>
<th>SURNAME</th>
<th>FIRST NAME</th>
<th>OTHER NAMES</th>
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<th>FORMER/MAIDEN NAME*(if any)*</th>
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<th>DATE OF BIRTH</th>
<th>IV.</th>
<th>SEX</th>
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<td>DAY</td>
<td>MONTH</td>
<td>YEAR</td>
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<tr>
<th>V</th>
<th>NATIONALITY</th>
<th>HOMETOWN</th>
<th>REGION</th>
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<th>MARITAL STATUS</th>
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### VII. PERMANENT ADDRESS

**RESIDENTIAL**

**POSTAL**

<table>
<thead>
<tr>
<th>H/No.:</th>
<th>Street No./Name:</th>
<th>Area/Suburb:</th>
<th>Town:</th>
<th>GPS:</th>
<th>E-mail Address</th>
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</table>

### VIII. TELEPHONE NO.:
23.5

GHANA

ADDITIONAL QUALIFICATION(S)
REGISTRATION APPLICATION FORMS

1.0 Personal Details

1.1 Title

1.2 Surname

1.3 First & Middle names(s)

1.4 Registration Number

1.5 Date of Birth (dd/mm/yy)

1.6 Registered Address

1.7 Current Workplace Address

1.8 Area of Practice

1.9 E-mail Address

2.0 Contact details (Home/Work/Mobile Telephone Numbers)

Education, Training and Research Department of the Pharmacy Council
2.0 Course Details

2.1 Details of additional degree acquired

2.2 Name of University which awarded the qualification

2.3 Date of award of degree

3.0 Declaration

I declare I am the above named pharmacist and shall be liable for the falsification of any information in relation to this registration.

3.1 Applicant’s Signature

3.2 Date (dd/mm/yy)

4.0 Documents to be submitted with the application

1. A certified copy of your additional qualification certificate
2. A transcript from the issuing University
3. Attestation letter from the Ghana College of Pharmacists
4. Catalogue of relevant scientific papers published
5. Resume of applicant
6. Proof of citizenship (i.e. Passport)
7. A copy of your work permit in your passport.
   (for non-Ghanaian applicants)
8. Evidence of payment of a prescribed processing fees

Please return completed forms and its attachments to the Education and Training Department of the Pharmacy Council, Ghana

Education, Training and Research Department of the Pharmacy Council
APPLICATION FOR REGISTRATION AS A PHARMACY TECHNICIAN

Please complete this form in BLOCK LETTERS. After fulfilling all the requirements, return the form including all the relevant documents to the Head Office or any of the Pharmacy Council Regional /Zonal Offices. Fees paid are not refundable. Affix recently taken passport sized photograph.

PASSPORT-SIZED PHOTOGRAPH TO BE ENDORSED BY REFEREE

SECTION 1: PERSONAL DATA

<table>
<thead>
<tr>
<th>TITLE</th>
<th>(Miss, Mr., Mrs..)</th>
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<table>
<thead>
<tr>
<th>I</th>
<th>SURNAME</th>
<th>FIRST NAME</th>
<th>OTHER NAMES</th>
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<th>FORMER/MAIDEN NAME (if any)</th>
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<tr>
<th>III</th>
<th>NATIONALITY (Attach proof of citizenship)</th>
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<th>IV</th>
<th>DATE OF BIRTH (DD/MM/YYYY)</th>
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V. PERMANENT ADDRESS

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<td>Area/Suburb:</td>
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<td>Town:</td>
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VI. TELEPHONE NUMBER

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<th>MOBILE:</th>
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VII. EMA ADDRESS

ILADDRESS
(B) EMPLOYMENT DATA

II EMPLOYER TYPE

[ ] GOVERNMENT/QUASI-GOVERNMENT

[ ] PRIVATE INSTITUTION/COMPANY

III AREA OF PRACTICE

[ ] Hospital/MoH

[ ] Industrial Pharmacy

[ ] Community

[ ] Academia/Research

[ ] Pharmaceutical Marketing

Please State workplace details ........................................................................................................

REGION ....................................................................................................................................

DISTRICT .................................................................................................................................

SECTION 2: QUALIFICATION

(Attach certified true copies of certificates, diplomas, degree etc)

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>DURATION</th>
<th>QUALIFICATION OBTAINED</th>
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Internship/National Service

(Attach certified true copies of National Service certificate)

<table>
<thead>
<tr>
<th>NSS No.</th>
<th>INSTITUTION</th>
<th>DURATION</th>
<th>NAME OF SUPERVISOR</th>
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SECTION 3: DECLARATION BY APPLICANT

I DECLARE that:

1. The information given in this form and in any supporting documents is true and accurate.
2. I have read, understood and will fully comply with procedures set out in the protocol for the voluntary register and the Practice Standards for Pharmacy Technicians issued by the Pharmacy Council.
3. I am applying to be listed in the Register of Pharmacy Technicians. I will comply with all relevant guidance issued by the Pharmacy Council and meet its continuing professional development requirements.
SECTION 4: REFEREE'S DECLARATION

The referee should either be a Pharmacist, a Senior Civil or Public Officer not below the rank of a Principal Executive Officer, a Medical Officer or a Leader of a recognised religious body.

I have known the applicant for ................... Years and certify that the information and documents submitted are true to the best of my knowledge.

Name.................................... Occupation Position ......................................................

Signature ................................ Postal Address..........................................................

Date..................................... Telephone Number......................................................

Official Stamp.

______________________________________________________________

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS...................................................................................

NAME OF INSPECTOR: ....................................................................................................

SIGNATURE: .................................. DATE ..............................................................

<table>
<thead>
<tr>
<th>Pharmacy Council Receipt No.</th>
<th>Amount Paid: GHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist Registration No.</td>
<td>Date:</td>
</tr>
</tbody>
</table>
PHARMACY BUSINESS APPLICATION FORM

NAME OF APPLICANT............................................................................................................
(Surname) (First Name) (Middle Name)
register...........................................................................................................................................
(Name of Proposed Pharmacy)

TYPE OF PHARMACY ■ COMMUNITY PHARMACY ■ HOSPITAL/CLINIC PHARMACY
If Community Pharmacy, tick the appropriate business type
■ RETAIL ■ WHOLESALE ■ WHOLESALE/RETAIL ■ MANUFACTURING
□ WHOLESALE

OWNERSHIP OF PROPOSED PHARMACY BUSINESS ■ GOV’T ■ PRIVATE
□ MISSION/NGO

BUSINESS ADDRESS

<table>
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<tr>
<th>POSTAL ADDRESS</th>
<th>TEL./MOBILE NO:</th>
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<tbody>
<tr>
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<td>FAX:</td>
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<td></td>
<td>EMAIL:</td>
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<td></td>
<td>WEBSITE</td>
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</table>

PROPOSED BUSINESS HOURS

<table>
<thead>
<tr>
<th>MONDAYS-FRIDAYS</th>
<th>SATURDAYS</th>
<th>SUNDAYS</th>
</tr>
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SHAREHOLDERS/PARTNERS:
1. .................................................................................................................................
2. .................................................................................................................................
3. .................................................................................................................................

<table>
<thead>
<tr>
<th>DIRECTORS</th>
<th>SIGNATURE</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td>S/N</td>
<td>List of other Pharmacies owned</td>
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<tr>
<td>-----</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>1</td>
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**LIST OF PHARMACISTS & PHARMACY SUPPORT STAFF IN THE FACILITY**

<table>
<thead>
<tr>
<th>No</th>
<th>Name (Surname First)</th>
<th>Practitioner type (P’csl/PTs/MCA)</th>
<th>Reg. No./PIN</th>
<th>Year of Registration</th>
<th>Number of years of Practice</th>
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</table>

(It is mandatory to register all your pharmacists and pharmacy support staff)

Signature of Applicant:...........................................................................................................

Designation:.................................................. Date:..................................................
LOCATION CLEARANCE FORM

PROPOSED LOCATION ADDRESS

H/No. .................................................. Town: ..............................................
Street name: ...................................... District: ..............................................
Suburb: ............................................... Region: ..............................................
GPS Code: ..........................................         

DIMENSION OF PROPOSED PHARMACY: LENGTH: ............... WIDTH: ............... 
HEIGHT: ..................... TOWN: ...................... DISTRICT: ...........................
REGION: ........................

<table>
<thead>
<tr>
<th>NAME OF NEAREST PHARMACY/PHARMACIES</th>
<th>RELATIVE DISTANCE FROM PROPOSED LOCATION</th>
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<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<tr>
<td>3.</td>
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</tbody>
</table>

SKETCH OF LOCATION


REGISTRATION & LICENSING POLICY
### DATA ON SUPERVISING PHARMACIST

**PROPOSED SUPERVISING PHARMACIST**

<table>
<thead>
<tr>
<th>NAME</th>
<th>REG. NO.</th>
<th>FORMER NAME (if any)</th>
<th>SIGNATURE</th>
<th>MONTH &amp; YEAR OF REG.</th>
</tr>
</thead>
</table>

- Passport-sized photograph

### CURRENT PLACE(S) OF WORK

**COMPLETE EACH ROW AS IT APPLIES TO YOU.**

<table>
<thead>
<tr>
<th>CURRENT PLACE(S) OF WORK</th>
<th>NAME &amp; LOCATION (TOWN/REGION) OF INSTITUTION</th>
<th>POSITION HELD</th>
<th>FROM - TO (Month &amp; Year)</th>
<th>WORKING HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Place(s) of work</td>
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<td>2.</td>
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### CURRENT PLACES OF WORK

**COMPLETE EACH ROW AS IT APPLIES TO YOU.**

<table>
<thead>
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<th>NAME &amp; LOCATION (TOWN/REGION) OF INSTITUTION</th>
<th>POSITION HELD</th>
<th>FROM - TO (Month &amp; Year)</th>
<th>WORKING HOURS</th>
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<td>Community Pharmacy</td>
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<td>4.</td>
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<tr>
<td>Hospital</td>
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<tr>
<td>Medical Representative</td>
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<tr>
<td>Academia</td>
<td>Others, industry, Administration etc. (Please specify)</td>
<td>1.</td>
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<tr>
<td></td>
<td>2.</td>
<td></td>
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</table>

### TO BE COMPLETED BY PROPOSED SUPERVISING PHARMACIST

I WISH TO CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND HEREBY ACCEPT TO BE THE SUPERVISING PHARMACIST FOR THE BUSINESS.

<table>
<thead>
<tr>
<th>NAME</th>
<th>REGISTRATION NUMBER</th>
<th>SIGNATURE</th>
<th>DATE</th>
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# ACKNOWLEDGEMENT SLIP

<table>
<thead>
<tr>
<th>DATE OF RECEIPT</th>
<th>NAME OF INSPECTOR/AUTHORISED OFFICER</th>
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<table>
<thead>
<tr>
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</tbody>
</table>

*IN CASE OF ANY ENQUIRES, PLEASE CONTACT US ON THE FOLLOWING ADDRESSES AND TELEPHONE LINES.*

**Greater Accra**
(233-302) 671427  | Near Adjabeng Court  |
|                  | Box AN 10344 Accra –North |

**Ashanti Region**
(233-3220) 31636/41455 | Regional Health Administration  |
|                      | P. O. Box KS 778Kumasi |

**Upper East Region**
(233-3820) 29208 | Veterinary office Building  |
|                  | P. O. Box BG 869 Bolgatanga |

**Upper West Region**
(233-3920) 22842 | Regional Administration Building, Wa  |

**Northern Region**
(233-3720) 23061 | Tamale Old Hospital  |
|                  | P. O. Box TL 1777 Tamale |

**Western Region**
(233-3120) 46391 | Regional Health Administration Sekondi |

**Volta Region**
(233-3820) 26324 | Old School of Hygiene  |
|                  | P. O. Box HP 1266 Ho |

**Brong Ahafo**
(233-3520) 26551 | Regional Administration Annex  |
|                  | P. O. Box 744Sunyani |

**Central Region**
(233-3321) 33233 | SIC Building Complex  |
|                  | Near STC Yard |
|                  | Box CC 1339 Cape Coast |

**Eastern Region**
(233-3420) 24699 | 2nd Floor SIC Office Complex  |
|                  | P. O. Box KF 2228 Koforidua |
OTCMS BUSINESS APPLICATION FORM

I, ........................................................................................................... apply for a licence to supply by retail ONLY Over The Counter medicines i.e. (Class C or OTC medicines) at:

PERSONAL DATA ON APPLICANT

<table>
<thead>
<tr>
<th>NATIONALITY</th>
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<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>SEX</th>
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</thead>
<tbody>
<tr>
<td>DAY</td>
<td>MONTH</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESIDENTIAL ADDRESS (h/No., Street, Suburb etc.)</th>
<th>POSTAL ADDRESS</th>
<th>TEL./MOBILE NO.:</th>
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<table>
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<tr>
<th>QUALIFICATION</th>
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<th>CERTIFICATE</th>
<th>INSTITUTION</th>
<th>YEAR OBTAINED</th>
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<table>
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<th>EMPLOYMENT DATA</th>
<th>(on last 2 places of work)</th>
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<tr>
<th>INSTITUTION</th>
<th>POSITION HELD</th>
<th>FROM - TO</th>
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</table>

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<tr>
<th>PRESENT OCCUPATION: .................................................................</th>
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</thead>
</table>

*Please attach evidence if you have retired, resigned or been redeployed

I certify that all the information I have provided above is correct.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
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</thead>
</table>

REGISTRATION & LICENSING POLICY
LOCATION CLEARANCE FORM

NAME OF APPLICANT: ............................................................................................................

POSTAL ADDRESS: .................................

TEL./MOBILE NO.: .................................

FAX.: ............................................

E-MAIL: ...........................................

LOCATION ADDRESS

H/No. ................................................

Street name:.................................

Suburb:...........................................

Town:.............................................

GPS Code:...........................................

District:...........................................

Region:.............................................

NAME OF NEAREST PHARMACY OR OTCMS SHOP

RELATIVE DISTANCE FROM PROPOSED LOCATION

1. ..................................................

2. ..................................................

3. ..................................................

SKETCH OF LOCATION

NB: THE PROPOSED SITE SHOULD BE A MINIMUM OF 1 KM (BY RADIUS) FROM THE NEAREST PHARMACY OR OTCMS SHOP
# REFEREE'S DECLARATION FORM

This form should be filled by a referee nominated by the applicant. The referee should either be a Pharmacist, a Senior Civil or Public Officer not below the rank of a Principal Executive Officer, a Senior Medical Officer or a Leader of a recognised religious body.

I ........................................................................................................ have known

(name of referee)

Mr./Mrs/Miss: .................................................................for.............................. years in my

(name of applicant)

capacity as ................................................................. I have no doubt that all the

(State relationship with applicant)
applicant's personal data provided are true and accurate. I am convinced that the applicant is capable of adhering to the rules and regulations that go with operating OTCMS shop.
I also confirm that the picture endorsed by me is the true likeness of the applicant.
I therefore recommend him/her to be considered for the licence.

................................................................. .................................................................
Signature of Referee Position

................................................................. .................................................................
Date Official Stamp

<table>
<thead>
<tr>
<th>Referee's Contact Address:</th>
<th>Tel./Mobile No.:</th>
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<tr>
<td></td>
<td>Fax.:</td>
</tr>
<tr>
<td></td>
<td>E-mail:</td>
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</table>
# ACKNOWLEDGEMENT SLIP

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<th>CODE NUMBER</th>
<th>OFFICIAL STAMP</th>
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- P. O. Box KS 778Kumasi

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- (233-3820) 26324
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- P. O. Box 744Sunnani

**Central Region**
- (233-3321) 33233
- SIC Building Complex
- Near STC Yard
- Box CC 1339 Cape Coast

**Eastern Region**
- (233-3420) 24699
- 2nd Floor SIC Office Complex
- P. O. Box KF 2228 Koforidua
1.0 FACILITY DATA
1.1 Name of Pharmacy: .................................................................
1.2 Location Address (H/No): .................................. GPS Code:....................
1.3 Suburb: ............................................................... Town: ................
1.4 District: .......................................................... Region: ................
1.5 Phone Number ..............................................................
1.6 Email Address ..............................................................

2.0 APPLICANT’S DETAILS
2.1 Surname: ..............................................................
2.2 Other names: ..............................................................
2.3 Date of Birth: ..............................................................
   (dd/mm/yyyy)
2.4 Practitioner Type: Pharmacy Technician: .................. MCA: ............
2.5 PIN No.: ................................................................. Year of Registration:.................................
   (For Pharmacy Technicians only)
2.6 Highest Educational Certificate (MCAs only): .................
   (Attach evidence of highest educational certificate)
   Year Obtained: ..............................................................
2.7 Number of years of practice as a PT/MCA: ....................
2.8 Phone Number: ..............................................................
2.9 Email Address: ..............................................................
### 3.0 OTHER PHARMACY SUPPORT STAFF IN THE FACILITY

<table>
<thead>
<tr>
<th>No</th>
<th>Name (Surname First)</th>
<th>Practitioner type (PTs/MCA)</th>
<th>Highest Educational background</th>
<th>Year of Qualification</th>
<th>Number of years of Practice</th>
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</tbody>
</table>

(Attach evidence of highest educational certificate of all support staff)

SIGNATURE OF APPLICANT: ........................................... DATE ........................

SUPERINTENDENT PHARMACIST ENDORSEMENT: ...................... DATE ...........

STAMP

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS ........................................................................................................
..................................................................................................................................................

NAME OF INSPECTOR: ................................................................................................................

SIGNATURE: ........................................... DATE .....................................................
APPLICATION FORMS FOR THE REGISTRATION OF OTCMS

1.0 APPLICANT’S DETAILS
1.1 Surname: .........................................................................................................................
1.2 Other Names: ...................................................................................................................
1.3 Date of Birth: ......................................................................................................................
   (dd/mm/yyyy)
1.4 Highest Educational Background .....................................................................................
   (Attach evidence of highest educational certificate)
1.5 Year Obtained: ...................................................................................................................
1.6 Number of years of practice as an OTCMS: .................................................................
1.7 Phone Number: ..............................................................................................................
1.8 Email Address: ................................................................................................................

2.0 FACILITY DATA
2.1 Name of License Holder: .................................................................................................
2.2 Licence Number: .............................................................................................................
2.3 Location Address (H/No): .................. GPS Code: ........................................
2.4 Suburb: ................................................................. Town: ........................................
2.5 District: .......................................................... Region: ...........................................

SIGNATURE OF APPLICANT: ............................................. DATE ......................

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS: .....................................................................................

NAME OF INSPECTOR: .....................................................................................................

SIGNATURE: ............................................. DATE ........................................
REGISTRATION FORMS FOR OTCMS ASSISTANTS

1.0 FACILITY DATA
1.1 Name of OTCMS Shop: .................................................................
1.2 Location Address (H/No): ........................................ GPS Code: ...........
1.3 Suburb: ................................................................. Town: ......................
1.4 District: ............................................................... Region: ....................
1.5 Phone Number: ........................................................................
1.6 Email Address: ...........................................................................

2.0 APPLICANT’S DETAILS
2.1 Surname: ..................................................................................
2.2 Other names: ...........................................................................
2.3 Date of Birth: ............................................................................
    (dd/mm/yyyy)
2.4 Highest Educational Background: .............................................
    (Attach evidence of highest educational certificate)
2.5 Year Obtained: ...........................................................................
2.6 Number of years of practice as an OTCMS Assistant: ............
2.7 Occupation: ............................................................................
2.8 Phone Number: ........................................................................
2.9 Email Address: ........................................................................
### 3.0 OTHER OTCMS ASSISTANTS IN THE FACILITY

<table>
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<tr>
<th>No</th>
<th>Name (Surname First)</th>
<th>Highest Educational background</th>
<th>Year of Qualification</th>
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</table>

(Attach evidence of highest educational certificate)

SIGNATURE OF APPLICANT: ........................................ DATE ........................

LICENCE HOLDER ENDORSEMENT: .................................. DATE ........................

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**FOR OFFICIAL USE ONLY**

REMARKS/RECOMMENDATIONS

...........................................................................................................................

NAME OF INSPECTOR: .................................................................................................

SIGNATURE: ........................................... DATE .............................................
PHARMACIST LICENSURE APPLICATION FORM

* PHARMACISTS
REGISTRATION NUMBER

(A) PERSONAL DETAILS
TITLE (Miss, Mr., Mrs., Dr., Professor)

* I. Surname First Name Other Names

II. FORMER/MAIDEN NAME (if any) III. NATIONALITY

IV. PERMANENT ADDRESS
RESIDENTIAL POSTAL
H/No.: Street No./Name:
Area/Suburb:
GPS Code:
Town:

V. TELEPHONE NUMBER VI. E-MAIL ADDRESS
LAND LINE: E-MAIL:
MOBILE:
(B) EMPLOYMENT DATA

* II  EMPLOYER TYPE

☐ GOVERNMENT/QUASI-GOVERNMENT

☐ PRIVATE INSTITUTION/COMPANY  ☐ SELF EMPLOYED

* III  AREA OF PRACTICE

☐ Hospital/MoH  ☐ Industrial Pharmacy  ☐ Community

☐ Academia/Research  ☐ Regulatory  ☐ Medical Representative

☐ Others, Please specify .................................................................

IV  DO YOU SUPERINTEND A PHARMACY?  Yes ☐  No ☐

V  NAME AND LOCATION OF COMMUNITY PHARMACY.................................

........................................................................................................

VI  DO YOU OWN THIS PHARMACY?  Yes ☐  No ☐

VII  NAME OF HOSPITAL/ INSTITUTION CURRENTLY EMPLOYED......................

........................................................................................................

REGION

DISTRICT

*(C) CONTINUING EDUCATION PROGRAMS ATTENDED

(ATTACH COPIES OF CERTIFICATE/CREDIT LOG BOOK)

<table>
<thead>
<tr>
<th>PROGRAMME</th>
<th>DATES</th>
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SIGNATURE: ................................................................. DATE: .....................

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS..........................................................

NAME OF INSPECTOR: ...........................................................................

SIGNATURE: ................................................................. DATE .....................

REGISTRATION & LICENSING POLICY
PHARMACY TECHNICIAN LICENSURE APPLICATION FORM

* PIN NUMBER

(A) PERSONAL DATA
TITLE ___________________________ (Miss, Mr., Mrs.)

<table>
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<tr>
<th></th>
<th>SURNAME</th>
<th>FIRST NAME</th>
<th>OTHER NAMES</th>
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II. FORMER/MAIDEN NAME (if any)

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* IV. DATE OF BIRTH (DD/MM/YY)

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V. PERMANENT ADDRESS

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<td>GPS Code:</td>
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|   | |
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| VI. | |

|   | |
|---| |
| VII. | |

|   | |
|---| |
| VII. | |
(B) EMPLOYMENT DATA

*I  EMPLOYER TYPE

☐ GOVERNMENT/QUASI-GOVERNMENT
☐ PRIVATE INSTITUTION/COMPANY

*II  AREA OF PRACTICE

☐ Hospital/MoH    ☐ Industrial Pharmacy    ☐ Community
☐ Academia/Research    ☐ Pharmaceutical Marketing

Please State workplace details ...........................................................................................................

REGION

DISTRICT

*(C) EDUCATION PROGRAMMES ATTENDED CONTINUING

(ATTACH COPIES OF CERTIFICATE)

<table>
<thead>
<tr>
<th>PROGRAMME</th>
<th>DATES</th>
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<td>1</td>
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<td>2</td>
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</table>

*(D) ATTACH EVIDENCE OF MEMBERSHIP OF A RECOGNISED NATIONAL PROFESSIONAL ASSOCIATION

SIGNATURE........................................................................................................ DATE...........................

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS...........................................................................................................

......................................................................................................................................................

NAME OF INSPECTOR: ....................................................................................................................

SIGNATURE: .................................................................................................................. DATE ................................
APPLICATION FORMS FOR VARYING
WORKPLACE DETAILS

1.0 FACILITY DATA

1.1 Name of New Facility: ..............................................................................................................

1.2 Location Address (H/No): .............................................. GPS Code: ......................................

1.3 Suburb: .................................................................................................................................

1.4 District: ............................................................ Region: ..........................................................

1.5 Phone Number ......................................................................................................................

1.6 Email Address ......................................................................................................................

1.7 Name of former Facility: ......................................................................................................

1.8 Location Address (H/No): .............................................. GPS Code: ......................................

Suburb: .................................................................................................................................

Town: ......................................................................................................................................

1.9 District: ............................................................ Region: ..........................................................

2.0 APPLICANT’S DETAILS

2.1 Surname: ..................................................................................................................................

2.2 Other names: ............................................................................................................................

2.3 Date of Birth: ..........................................................................................................................

(  dd/mm/yyyy)

2.4 Phone Number: .......................................................... Email: .................................................

SIGNATURE OF APPLICANT: ............................................. DATE .................................

ENDORSED BY MANAGER OF CURRENT WORKPLACE: ............ DATE ..................

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS..............................................................................................

NAME OF INSPECTOR: ................................................................................................................

SIGNATURE ...............................................................................................................................
APPLICATION FOR VARYING PHARMACY BUSINESS OPERATING PERMIT

I………………………………………………. wish to apply for the following change(s)

(Authorised representative)

Please tick as appropriate

Section A - Change of business name ☐
Section B - Change of ownership ☐
Section C - Change of location ☐
Section D - Change of Pharmacist ☐

Signature of Applicant………………………… Designation…………………………

Date……………………………………………………..
SECTION A

CHANGE OF BUSINESS NAME

<table>
<thead>
<tr>
<th>Full Name of Applicant</th>
</tr>
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</table>

I, ........................................................................................................ hereby apply to change the name of my pharmacy from 

<table>
<thead>
<tr>
<th>Current name of pharmacy</th>
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TO BE COMPLETED BY SUPERINTENDENT PHARMACIST

I wish to certify that all the above information is correct to the best of my knowledge and hereby accept to be the Superintendent Pharmacist for the business.

<table>
<thead>
<tr>
<th>Name of Superintendent Pharmacist</th>
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<table>
<thead>
<tr>
<th>Registration Number</th>
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<table>
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<tr>
<th>Date Signed</th>
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</table>
SECTION B

CHANGE OF OWNERSHIP

HAS THERE BEEN ANY CHANGE IN SHAREHOLDING/DIRECTORSHIP? Yes [ ] No [ ]

*If yes complete the following tables*

<table>
<thead>
<tr>
<th>ORIGINAL SHAREHOLDERS</th>
<th>ORIGINAL DIRECTORS</th>
</tr>
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<tbody>
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<thead>
<tr>
<th>NEW SHAREHOLDERS</th>
<th>NEW DIRECTORS</th>
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</table>

*TO BE COMPLETED BY SUPERINTENDENT PHARMACIST*

I wish to certify that all the above information is correct to the best of my knowledge and hereby accept to be the Superintendent Pharmacist for the business.

.......................................................... ..........................................................
(NAME OF SUPERINTENDENT PHARMACIST) (REGISTRATION NUMBER)

.......................................................... ..........................................................
(Signature) (Date Signed)
SECTION C

CHANGE OF LOCATION

I ........................................................................................................ hereby apply

(FULL NAME OF APPLICANT)

to relocate .................................................................

(NAME OF PHARMACY)

as a ................................................................. Pharmacy Business

(Retail, Wholesale or Wholesale/Retail)

to .................................................................

(Location address of proposed premises i.e. H/No., street, Suburb etc.)

CURRENT LOCATION OF PHARMACY

(Location address of current premises i.e. H/No., Street, Suburb etc.)

REASON(S) FOR RELOCATION


BUSINESS PARTICULARS

<table>
<thead>
<tr>
<th>POSTAL ADDRESS:</th>
<th>TEL./MOBILE NO.:</th>
</tr>
</thead>
<tbody>
<tr>
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<td>FAX:</td>
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<td>E-MAIL:</td>
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PROPOSED BUSINESS HOURS

<table>
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<tr>
<th>MONDAYS-FRIDAYS</th>
<th>SATURDAYS</th>
<th>SUNDAYS</th>
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<th>SHAREHOLDERS</th>
<th>DIRECTORS</th>
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</table>

TO BE COMPLETED BY SUPERINTENDENT PHARMACIST

I wish to certify that all the above information is correct to the best of my knowledge and hereby accept to be the Superintendent Pharmacist for the business.

(NAME OF SUPERINTENDENT PHARMACIST)  (REGISTRATION NUMBER)

(Signature)  (Date Signed)
SECTION D

LOCATION CLEARANCE FORM
(For applicants changing location)

NAME OF APPLICANT

POSTAL ADDRESS

TELEPHONE:
FAX:
E-MAIL:

PROPOSED BUSINESS NAME:

TYPE OF PHARMACY BUSINESS
☐ RETAIL ☐ WHOLESALE
☐ WHOLESALE/RETAIL

LOCATION:

(H/No., Street, Suburb, etc.)

DIMENSION OF STORE: LENGTH: .............. WIDTH: ....................
HEIGHT: .................. TOWN: ................. DISTRICT: ...................

REGION:..................

<table>
<thead>
<tr>
<th>NAME OF NEAREST PHARMACY/PHARMACIES</th>
<th>RELATIVE DISTANCE FROM PROPOSED LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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</table>

SKETCH OF LOCATION

REGISTRATION & LICENSING POLICY
SECTION E
CHANGE OF PHARMACIST(S)

SUPERINTENDENT PHARMACIST:

*Fill this section if Superintendent Pharmacist has changed.*

**NAME OF SUPERINTENDENT PHARMACIST:** .................................................................

**FORMER NAME (if any)** .................................................................  **REG. NO.:** .................................................................

**SIGNATURE:** .................................................................

**YEAR OF REG.:** .................................................................

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<th>RESIDENTIAL ADDRESS</th>
<th>TELEPHONE:</th>
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*(Last 2 places of work of Superintendent Pharmacist)*

<table>
<thead>
<tr>
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<th>NAME OF INSTITUTION</th>
<th>POSITION HELD</th>
<th>FROM - TO</th>
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<tbody>
<tr>
<td>Community Pharmacy</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hospital</td>
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<td></td>
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<tr>
<td>Medical Representative</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Academia</td>
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<tr>
<td>Industry</td>
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<tr>
<td>Other (Please specify)</td>
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</tbody>
</table>
**FOR OFFICIAL USE ONLY**

<table>
<thead>
<tr>
<th>NAME OF INSPECTOR OR AUTHORIZED OFFICER</th>
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<table>
<thead>
<tr>
<th>DATE OF RECEIPT</th>
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<table>
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<tr>
<th>CODE NUMBER</th>
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**ACKNOWLEDGEMENT SLIP (TO BE DETACHED AND GIVEN TO APPLICANT)**

<table>
<thead>
<tr>
<th>DATE OF RECEIPT</th>
<th>NAME OF INSPECTOR/AUTHORISED OFFICER</th>
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<thead>
<tr>
<th>CODE NUMBER</th>
<th>OFFICIAL STAMP</th>
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<th>TIME</th>
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<table>
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<tr>
<th>SIGNATURE</th>
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</table>
APPLICATION FORM FOR VARYING OTCMS LICENCE

I, ........................................................................................................ wish to apply to

(Full Name of Applicant)

relocate my OTCMS business to

H/No. ................................................................ Street ......................... Suburb .................
(Location address of proposed premises i.e. H/No., Street, Suburb etc.)

Town: ............... GPS Code: ............... District: ............. Region: .................

CURRENT LOCATION

H/No. ................................................................ Street ......................... Suburb .................
(Location address of proposed premises i.e. H/No., Street, Suburb etc.)

Town: ............... GPS Code: ............... District: ............. Region: .................

LICENCE NUMBER ...........................................................................

REASON(S) FOR RELOCATION

........................................................................................................
........................................................................................................
........................................................................................................
PERSONAL DATA ON APPLICANT

NATIONALITY

DATE OF BIRTH

SEX

DAY MONTH YEAR AGE MALE FEMALE

RESIDENTIAL ADDRESS
(H/No., Street, Suburb etc.)

POSTAL ADDRESS

TEL./MOBILE NO.:
FAX.:
E-MAIL:

LOCATION CLEARANCE FORM

NAME OF APPLICANT: .................................................................

POSTAL ADDRESS:

TEL./MOBILE NO.:
FAX.:
E-MAIL:

LOCATION .................................................................
(H/No., Street. Suburb, etc.)

TOWN: .........................  DISTRICT: .........................  REGION: .........................

NAME OF NEAREST PHARMACIES OR LICENSED CHEMICAL SELLERS
RELATIVE DISTANCE FROM PROPOSED LOCATION

1.
2.
3.

SKETCH OF LOCATION

I certify that all the information I have provided above is correct.

.................................................................  .................................................................
SIGNATURE  DATE

NB: THE PROPOSED SITE SHOULD BE A MINIMUM OF 1 KM (BY RADIUS) FROM THE NEAREST PHARMACY OR OTCMS SHOP

To be completed by Applicant

REGISTRATION & LICENSING POLICY
**FOR OFFICIAL USE ONLY** *(to be completed at point of submission)*

<table>
<thead>
<tr>
<th>NAME OF INSPECTOR OR AUTHORIZED OFFICER</th>
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<tr>
<td>DATE OF RECEIPT</td>
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<tr>
<td>CODE NUMBER</td>
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</tbody>
</table>

**ACKNOWLEDGEMENT SLIP** *(TO BE DETACHED AND GIVEN TO APPLICANT)*

<table>
<thead>
<tr>
<th>DATE OF RECEIPT</th>
<th>NAME OF INSPECTOR/AUTHORISED OFFICER</th>
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<th>SIGNATURE</th>
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</table>
23.17
APPLICATION FOR RENEWAL OF REGISTRATION FOR PHARMACY BUSINESS

LIC. NO. PC/ ............................................ DATE: ...........................................
NAME OF BUSINESS: .................................................................

LOCATION OF BUSINESS: ...........................................................
(Hi/No. Street, Suburb, Town, etc)

TYPE OF PHARMACY  □ COMMUNITY PHARMACY  □ HOSPITAL/CLINIC PHARMACY
If Community Pharmacy, tick the appropriate business type
□ RETAIL  □ WHOLESALE  □ WHOLESALE/RETAIL  □ MANUFACTURING
WHOLESALE

OWNERSHIP OF PHARMACY BUSINESS  □ GOVT  □ PRIVATE  □ MISSION/NGO

BUSINESS POSTAL ADDRESS

TEL./MOBILE NO.: 
FAX: 
E-MAIL ADDRESS:

BUSINESS WORKING HOURS

<table>
<thead>
<tr>
<th>MONDAYS-FRIDAYS</th>
<th>SATURDAYS</th>
<th>SUNDAYS</th>
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SUPERINTENDENT PHARMACIST

<table>
<thead>
<tr>
<th>NAME</th>
<th>REG. NO.</th>
<th>YEAR OF REG.</th>
<th>WORKING HOURS</th>
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EMPLOYMENT DATA, STATE LAST TWO PLACES OF WORK

<table>
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<tr>
<th>Community Pharmacy</th>
<th>NAME OF INSTITUTION</th>
<th>POSITION HELD</th>
<th>YEAR/FROM - TO</th>
<th>WORKING HRS.</th>
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</thead>
</table>

EMPLOYMENT DATA, STATE ANY OTHER CURRENT PLACE OF WORK

<table>
<thead>
<tr>
<th>Hospital Practice</th>
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<tbody>
<tr>
<td>Medical Representative</td>
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<tr>
<td>Academia</td>
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<tr>
<td>Regulatory</td>
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<tr>
<td>Others (Please specify)</td>
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</table>

NB:  TO BE SUBMITTED BY THE SUPERVISING PHARMACIST

REGISTRATION & LICENSING POLICY
LIST OF PHARMACISTS & PHARMACY SUPPORT STAFF IN THE FACILITY

<table>
<thead>
<tr>
<th>No</th>
<th>Name (Surname First)</th>
<th>Practitioner type (P'clist/PTs/MCA)</th>
<th>Reg. No./PIN</th>
<th>Year of Registration</th>
<th>Number of years of Practice</th>
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</tbody>
</table>

(It is mandatory to register all your pharmacists and pharmacy support staff)

TO BE COMPLETED BY PROPOSED SUPERVISING PHARMACIST

I WISH TO CERTIFY THAT ALL THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND HEREBY ACCEPT TO BE THE SUPERVISING PHARMACIST FOR THE BUSINESS.

<table>
<thead>
<tr>
<th>(NAME)</th>
<th>(REGISTRATION NUMBER)</th>
</tr>
</thead>
<tbody>
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</table>

(SIGNATURE) (DATE)

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS:..........................................................................................

..................................................................................................................................

..................................................................................................................................

INSPECTOR:..........................................

SIGNATURE:.....................................   DATE:...........................................
23.18

GHANA

OTCMS BUSINESS LICENCE
RENEWAL FORMS

1.0 FACILITY DATA
1.1 Name of Licence Holder: ..........................................................................
1.2 Licence Number: ...................................................................................
1.3 Location Address (H/No): ...................................................................... GPS Code: ................................
1.4 Suburb: ......................................................... Town: ...........................
1.5 District: ......................................................................................... Region: ...........................
1.6 Phone Number: ....................................................................................
1.7 Email Address: ....................................................................................

2.0 BUSINESS WORKING HOURS

<table>
<thead>
<tr>
<th>MONDAYS-FRIDAYS</th>
<th>SATURDAYS</th>
<th>SUNDAYS</th>
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3.0 CAPACITY DEVELOPMENT DATA

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<th>Training Programme(s) Attended</th>
<th>Organiser(s)</th>
<th>Date</th>
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<tbody>
<tr>
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</table>

3.0 DATA ON OTCMS ASSISTANTS IN THE FACILITY

<table>
<thead>
<tr>
<th>No</th>
<th>Name (Surname First)</th>
<th>Highest Educational background</th>
<th>Year of Qualification</th>
<th>Number of years of Practice</th>
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<tbody>
<tr>
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</table>

(Attach evidence of highest educational certificate)

FOR OFFICIAL USE ONLY

REMARKS/RECOMMENDATIONS: ..........................................................................

NAME OF INSPECTOR: ..............................................................................

SIGNATURE: ....................................................................................... DATE: .................................
REGISTRATION & LICENSING POLICY

FOR PHARMACISTS, PHARMACY SUPPORT STAFF & PHARMACEUTICAL BUSINESSES IN GHANA

NOVEMBER 2017
Registration & Licensing

Policy

for

Pharmacists, Pharmacy

support staff

& Pharmaceutical

Businesses in

Ghana

November, 2017
VISION

TO GUARANTEE THE HIGHEST LEVEL OF PHARMACEUTICAL CARE

MISSION STATEMENT

The mission of the Pharmacy Council is to secure the highest level of pharmaceutical care by ensuring competent pharmaceutical care providers who practice with agreed standards and are accessible to the whole population.

In addition, the Pharmacy Council shall collaborate with related agencies and international pharmaceutical organisations to enhance our effectiveness and our contribution on rational medicine use in the nation. This mission shall be carried out with dedication, integrity and professionalism.
# TABLE OF CONTENT

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
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<tbody>
<tr>
<td>TABLE OF CONTENT</td>
<td>iii</td>
</tr>
<tr>
<td>FORWARD</td>
<td>v</td>
</tr>
<tr>
<td>ABBREVIATIONS</td>
<td>vi</td>
</tr>
<tr>
<td>GLOSSARY OF TERMS/ DEFINITIONS</td>
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</tr>
<tr>
<td>1.0 POLICY BACKGROUND</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Underpinning Philosophy and Legal framework</td>
<td>2</td>
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<tr>
<td>1.2 Benefits to Practitioners</td>
<td>3</td>
</tr>
<tr>
<td>1.3 Benefits to the Public</td>
<td>3</td>
</tr>
<tr>
<td>1.4 Benefits for employers</td>
<td>4</td>
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<td>2.0 ENABLING LEGISLATION</td>
<td>4</td>
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<tr>
<td>3.0 SCOPE</td>
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<td>4.0 BROAD OBJECTIVES AND STRATEGIES</td>
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<tr>
<td>5.0 PRE-REGISTRATION INTERNSHIP FOR PRACTITIONERS</td>
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<td>6.0 PRACTITIONER REGISTRATION</td>
<td>8</td>
</tr>
<tr>
<td>6.1 Conditions for registration of pharmacists</td>
<td>8</td>
</tr>
<tr>
<td>6.2 Conditions for registration of additional qualifications of pharmacists</td>
<td>9</td>
</tr>
<tr>
<td>6.3 Conditions for registration of pharmaceutical support staff</td>
<td>10</td>
</tr>
<tr>
<td>6.3.1 Pharmacy Technicians</td>
<td>10</td>
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<tr>
<td>6.3.2 Medicine Counter Assistants (MCAs)</td>
<td>10</td>
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<tr>
<td>6.3.3 Over The Counter Medicine Sellers (OTCMS)</td>
<td>11</td>
</tr>
<tr>
<td>6.3.4 OTCMS Assistants</td>
<td>11</td>
</tr>
<tr>
<td>7.0 CONDITIONS FOR RENEWAL OF PRACTITIONER'S REGISTRATION</td>
<td>11</td>
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<tr>
<td>7.1 Renewal of registration as a pharmacist</td>
<td>11</td>
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<tr>
<td>7.2 Renewal of registration as a Pharmacy Technician</td>
<td>12</td>
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<td>7.3 Renewal of registration as a Medicine Counter Assistant</td>
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<td>7.4 Renewal of registration as an Over-The-Counter Medicine Seller</td>
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<tr>
<td>7.5 Renewal of registration as an Over-The-Counter Medicine Sellers Assistant</td>
<td>14</td>
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<td>8.0 FITNESS TO PRACTICE</td>
<td>14</td>
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<tr>
<td>9.0 TRANSPORTATION AND HANDLING OF MEDICINES</td>
<td>15</td>
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<tr>
<td>10.0 REGISTRATION OF VEHICLE(S) FOR THE DELIVERY OF MEDICINES</td>
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<tr>
<td>11.0 VARYING OF SUPPORT STAFF WORKPLACE DETAILS</td>
<td>16</td>
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<td>12.0 CHANGE OF NAME OF A REGISTERED PRACTITIONER</td>
<td>16</td>
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13.0 PHARMACY BUSINESS REGISTRATION

13.1 Operational Framework
13.2 Specific Objectives
13.3 Membership
13.4 The role of the Chairman to the PFTC
13.5 Meetings of the Committee
13.6 Term of Office

14.0 NEW PHARMACY BUSINESS APPLICATIONS

15.0 RENEWAL APPLICATIONS

16.0 CONDITIONS FOR VARYING PHARMACY BUSINESS OPERATING PERMIT

16.1 Change of Ownership
16.2 Change of Business Name
16.3 Change of Pharmacist
16.4 Change of Location

17.0 CONDITIONS AND PROCEDURE FOR SUSPENSION OF BUSINESS

18.0 CONDITIONS FOR THE ISSUE OF PHARMACY BUSINESS OPERATING PERMITS

19.0 EQUITABLE AND ACCESSIBLE DISTRIBUTION OF PHARMACEUTICAL PREMISES AND PERSONNEL

20.0 RIGHT OF APPEAL AND GRIEVANCE REPORTING

21.0 DESIRED POLICY OUTCOMES

22.0 POLICY REVIEW

23.0 APPENDIX

23.1 Application form for pharmacy internship programme
23.2 Application forms for experiential training of HND Dispensing Technology graduates
23.3 Application forms for the registration of GPPQE
23.4 Application forms for the registration of newly qualified pharmacists
23.5 Application forms for the registration of additional qualifications of pharmacists
23.6 Application forms for the registration of pharmacy technicians
23.7 Application forms for the registration of pharmacy business
23.8 Application forms for the registration of OTCMS shop
23.9 Application forms for the registration of pharmaceutical support staff
23.10 Application forms for the registration of OTCMS
23.11 Application forms for the registration of OTCMS assistants
23.12 Application forms for the renewal of pharmacist' licence
23.13 Application forms for the renewal of pharmacy technician' licence
23.14 Application forms for varying pharmacy support staff workplace details
23.15 Application forms for the varying of pharmacy business operating permit
23.16 Application forms for the varying of OTCMS business operating permit
23.17 Application forms for the renewal of pharmacy business operating permit
23.18 Application forms for the renewal of OTCMS business operating permit
FORWARD

This policy seeks to ensure the harmonisation of the visions, goals, and operational decisions of the Council. We shall ensure that the pharmaceutical service providers work characteristics is built around the standards and customs of the pharmacy profession. It is a known fact that registered practitioners have a greater loyalty to their profession, and greater concern for recognition by their professional peers. The implementation of this registration and licensing policy and its guidelines must therefore become a natural part of the culture and accepted mode of operation of the Council. The Council shall remain committed to and demonstrate its proactive interest and concern for the needs of the public through effective and collaborative public education, publicity, public relation, and applied research. It is my hope that this new registration and licensing policy will form the basis for the transformation of pharmacy practice throughout the country.

Pharm (Mrs.) Doris Addae-Afoakwa
Board Chair
ABBREVIATIONS

CPD – Continuous Professional Development
ETR – Education Training & Research
EIG – Enforcement & Intelligence Gathering
FPPS – Faculty of Pharmacy & Pharmaceutical Sciences
HeFRA – Health Facilities Regulatory Agency
HND – Higher National Diploma
KNUST – Kwame Nkrumah University of Science & Technology
LQA – Legal and Quality Assurance
MCA – Medicine Counter Assistant
MIS/PI – Management Information System & Practitioner Identification
OTCMS – Over The Counter Medicine Seller
PC – Pharmacy Council
PFTC – Pharmaceutical facilities Technical Committee
ROC – Regional Offices Coordination
R&L – Registration and Licensing
SSSCE – Senior Secondary School Certificate Examination
WASSCE – West Africa Senior Secondary Certificate Examination
GLOSSARY OF TERMS/ DEFINITIONS

The following definitions describe the way the term is used in this document. The Glossary is not intended to provide or imply a globally adopted definition of the term.

**Fitness to Practice** - to have the skills, knowledge, character and health required to perform ones' professional job safely and effectively.

**Practitioner** - Refers to a registered pharmacist or pharmacy support staff

**Pharmacy support staff** - Refers to a pharmacy technician, OTCMS, OTCMS assistant, or an MCA

**Registration** - Is the process of entering names of practitioners or facilities into a register to prove that they meet a general standard of quality in performing their roles and responsibilities providing a service.

**Pharmaceutical care** - The responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life.

**Minimum Credit** - Refers to a CPD score of not less than 10 points required by a practitioner annually to be eligible to practice.

**Pharmacy Business** - Refers to pharmacies and OTCMS shops

**Vehicle** - A device for carrying or transporting medicines

**Deprived District** - A district without a community pharmacy