Pharmacy Membership Application Form

Operated by VAULT (SL) Limited

HEALTHCONNECT™ MEMBERSHIP APPLICATION

1. APPLICANT INFORMATION		
Pharmacy Name:		
Pharmacy Registration No.	Pharmacy Code:	Pharmacy Phone:
Pharmacy Current address:		
City:	Area/District:	Email:
Pharmacy Registered Type *(Please circle)*	Clinic Status	Pharmacy Primary Contact *(Please indicate Below)*
Wholesaler ☐ Retailer ☐	Private☐ Government ☐	
Please Indicate if Clinic is registered with the Pharmacy Board		

2. PHARMACY OWNER INFORMATION		
Name of Owner:		
Owner address:		Area/District
Owner Phone:	Owner E-mail:	Postal Address
City:	Nationality:	

3. PHARMACIST INFORMATION		
First name	Middle	Last
Permanent Address	City	Area/ District
Mobile Phone No.	Email	License/Certificate of operations date and No:

DRUG/PRODUCT DETAILS
Please indicate and tick the types of drugs you deal with: