



**MINISTRY OF HEALTH & WELLNESS
APPLICATION FORM FOR PHARMACEUTICAL ESTABLISHMENTS**

A: APPLICANT INFORMATION		
Name of Owner:		Application Date: _____ DD/MM/YYYY
Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Age: <input type="text"/> <input type="text"/>	SSB #: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Applicant's Permanent Address:		Country of Birth:
Telephone Number(s):		Citizenship:
e-mail address:		
B: FACILITY INFORMATION		
Name of Establishment: (As indicated on Trade License)		
Establishment Address:		
Business Registration Number:		
Tax Identification Number:		
Opening Hours: Monday- Friday: _____ Sunday: _____ Saturday: _____ Holiday: _____		
FACILITY TYPE : (Please tick below)	NATURE OF BUSINESS: (Please tick below)	APPLICATION IS FOR:
<input type="checkbox"/> Retail <input type="checkbox"/> Wholesale <input type="checkbox"/> Manufacturing <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> Retail sale <input type="checkbox"/> Export <input type="checkbox"/> Wholesale <input type="checkbox"/> Manufacturing <input type="checkbox"/> Import <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Transshipment	<input type="checkbox"/> New License <input type="checkbox"/> Renewal <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Change of Name <input type="checkbox"/> Change of location <input type="checkbox"/> Expansion of service
Type of Medication to be sold or imported: (Please tick below <u>all</u> that are applicable)		
<input type="checkbox"/> General OTC <input type="checkbox"/> Pharmacy OTC	<input type="checkbox"/> General Prescription Medications <input type="checkbox"/> Antibiotics	<input type="checkbox"/> Controlled Drugs <input type="checkbox"/> Dietary Supplements
C: DETAILS OF THE PHARMACIST (S)		
Principal Pharmacist		
Full name of Principal Pharmacist		
Pharmacist Registration number (if applicable)		
Permanent Address		
Working hours of pharmacist (describe shift schedule if necessary)		
Other Pharmacist(s) Employed at Facility		
Name of Other Pharmacists		Working Hours (describe shift schedule if necessary)
1.		
2.		
3.		
4.		
5.		
D: AFFIDAVIT		
I, _____ (Applicant/Owner) hereby affirm that the statement in this application is true and correct. Application is hereby made to operate a pharmaceutical facility in Belize.		
_____ Applicant - Print Name and Sign		_____ Date (dd/mm/yyyy)
(SEE REQUIREMENTS ON OVERLEAF)		

NEW FACILITY LICENSE	
Documents to be Submitted with Application Form for New Facility	<i>FOR OFFICIAL USE ONLY</i>
Facility floor plan for the business	
Business certificate of registration	
Copy of applicant's passport or social security card	
Copy of pharmacist (s) passport or social security card	
Copy of Chemist and Druggist Certificate (for each pharmacist employed)	
Letter of employment between owner and pharmacist (s) (if owner is not the pharmacist)	
Treasury receipt of payment	

LICENSE RENEWAL	
Documents to be Submitted with Application Form for License Renewal	<i>FOR OFFICIAL USE ONLY</i>
Copy of the most recent facility license from the Ministry of Health & Wellness	
Copy of applicant's passport or social security card	
Copy of pharmacist(s) passport or social security card	
Copy of Chemist and Druggist Certificate (for each pharmacist employed)	
Letter of employment between owner and pharmacist (s) (if owner is not the pharmacist)	
Treasury Receipt of payment	

OFFICIAL USE ONLY:

Date Received	
Date of facility inspection	
Assessment comments	
Date approved/ refused	

Instructions for Applicants

A. PLEASE NOTE THE FOLLOWING REQUIREMENTS TO BE SUBMITTED WITH APPLICATION FORM FOR NEW APPLICANT:

- i. Facility floor plan for the business.
- ii. Business certificate of registration.
- iii. For non-resident applicant, a notarized copy of passport. For resident, a copy of Belizean passport. Social security card will also be accepted.
- iv. Copy of pharmacist's passport or social security card.
- v. Copy of Chemist and Druggist Certificate (for each pharmacist employed).
- vi. Official translation of all documents to English Language, if documents are in any other language.
- vii. Letter of employment between owner and Pharmacist (s) (if owner of the facility is not the pharmacist), signed by both.
- viii. Resident applicant(s): Pharmacist(s) and the owner(s) need to provide a most recent police record from the Belize Police Department (not older than six months). Non- resident applicant(s): Police Record from country of citizenship and from Belize, if living in the country for less than six (6) months.
- ix. Treasury receipt of payment. Please note annual registration fee paid to the nearest Government Sub-treasury: Retail \$250.00, Import/Wholesale \$550.00 and Manufacturing \$5000.00. Paid to Treasury Department, providing the following:

Cost Center	19068
Programme	120
Activity	14
Line Item	11724

B. PLEASE NOTE THE FOLLOWING REQUIREMENTS TO BE SUBMITTED WITH APPLICATION FORM FOR RENEWAL:

- i. Copy of the most recent approved license from the Ministry of Health & Wellness.
- ii. For non-resident applicant, a notarized copy of passport. For resident, a copy of Belizean passport. Social security card will also be accepted.
- iii. Copy of pharmacist's passport or social security card.
- iv. Copy of Chemist and Druggist Certificate (for each pharmacist employed).
- v. Official translation of all documents to English Language, if documents are in any other language.
- vi. Letter of employment between owner and Pharmacist (s) (if owner of the facility is not the pharmacist), signed by both.
- vii. Resident applicant(s): Pharmacist(s) and the owner(s) need to provide a most recent police record from the Belize Police Department (not older than six months). Non- resident applicant(s): Police Record from country of citizenship and from Belize, if living in the country for less than six (6) months.
- viii. Treasury receipt of payment. Please note annual registration fee paid to the nearest Government Sub-treasury: Retail \$250.00, Import/Wholesale \$550.00 and Manufacturing \$5000.00. Paid to Treasury Department, providing the following:

INSTRUCTION FOR APPLICANT:

- i. Ensure that **ALL** sections of the application form are fully completed before submission. Send completed application form with stated requirements (see above) to:
Director of Drug Inspectorate Unit, Ministry of Health & Wellness, 3rd Floor East Block Building, Belmopan City, Cayo, Belize.
- ii. Incomplete applications **WILL NOT** be accepted.
- iii. A completed application form is valid for a period of three months **ONLY** after submission, after which, the applicant will be required to submit a new application form.
- iv. Submission of applications will be accepted Monday-Friday from 8:00 am-3:00 pm.
- v. Approval turnaround time is between 4-6 weeks.
- vi. Approved certificates can be collected from the front desk of The Ministry of Health and Wellness: Monday-Friday from 8:30am-3:30pm.

For additional information kindly contact
Drug Inspectorate Unit, Ministry of Health & Wellness, Belize:
Telephone number: 501-822-2325
Email address: inspectoratemohw@health.gov.bz