THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

APPLICATION FOR MEDICAL REPRESENTATIVE'S PERMIT

As stipulated under Pharmacy Practice Regulations, 2011

Registrar,
Pharmacy Council,
P. O. Box 31818,
Dar es salaam.

I / We ……
of……Postal address……Tel, No……Fax……and email……being engaged in the sale and supply of pharmaceuticals and poisons, hereby make application that our medical representative Dr/Mr/Mrs/Ms (full name))……be Permitted to possess pharmaceuticals and poisons as scheduled below, for the purpose of giving free samples to persons who may lawfully posses such pharmaceuticals and poisons.

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SCHEDULE

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Date…… Signed ……
Applicant and stamp

FOR OFFICIAL USE ONLY

Fees Tshs…… Receipt No……of……

Permission granted/not granted because……

Permit No……Approved by Management meeting No……of……

…… ……
Date Signature of Registrar and stamp