



Ministry of Health

Form: PMPB/D/001



Pharmacy, Medicines & Poisons Board

**REQUEST FOR IMPORTATION OF A MEDICINAL PRODUCT AS A DONATION**

**1. NAME AND ADDRESS OF APPLICANT**

Phone:

Fax:

E-mail:

Name of Responsible Officer:

**2. NAME AND ADDRESS OF BENEFICIARY (If different from 1)**

Phone:

Fax:

E-mail:

Contact Person:

**3. NAME AND ADDRESS OF THE DONOR**

Phone:

Fax:

E-mail:

Contact Person:

**4. LIST OF MEDICINES PROPOSED FOR DONATION**

Item Description (Includes generic and brand name, strength, pack size, and quantity requested )	Man. Date (mm/yy)	Expiry Date (mm/yy)	Manufacturer	Country of origin	Supplier (if applicable)	Delivery time (wk.)	Approved or Rejected and Remarks	PMPB Ref. No.
Item 1:								
Qty:								
Item 2:								
Qty:								
Item 3:								
Qty:								
Item 4:								
Qty:								
Item 5:								
Qty:								

<b>Item Description</b> (Includes generic and brand name, strength, pack size. and quantity requested )	<b>Man. Date</b> <b>(mm/yy)</b>	<b>Expiry Date</b> <b>(mm/yy)</b>	<b>Manufacturer</b>	<b>Country of origin</b>	<b>Supplier</b> (if applicable)	<b>Delivery time</b> <b>(wk.)</b>	<b>Approved or Rejected and Remarks</b>	<b>PMPB Ref. No.</b>
<b>Item 6:</b>								
<b>Qty:</b>								
<b>Item 7:</b>								
<b>Qty:</b>								
<b>Item 8:</b>								
<b>Qty:</b>								
<b>Item 9:</b>								
<b>Qty:</b>								
<b>Item 10:</b>								
<b>Qty:</b>								

*(Attach additional photocopied pages labeled from item 11 if required)*

Items No. Approved..... Registrar PMPB..... Date/Stamp.....

Items No. Rejected..... Registrar PMPB..... Date/stamp.....

Name of Customs Clearing Office.....Authorized Name and Signature.....Date/stamp.....

Port of entry: .....