



South African Pharmacy Council

Form is valid for
2023 only

591 Belvedere Street, Arcadia, Pretoria, 0083; Private Bag X40040, Arcadia, 0007;
Tel: 0861 7272 00; Fax: 27 (12) 321 1479; E-mail: customercare@sapc.za.org; Website: www.sapc.za.org

APPLICATION FOR ISSUING OF A DUPLICATE CERTIFICATE FOR A PHARMACY, OWNER OR RESPONSIBLE PHARMACIST IN TERMS OF THE PHARMACY ACT 53 OF 1974

Please use black ink and complete in **BLOCK CAPITALS**.
Return to: **The Registrar, South African Pharmacy Council, to the postal address above**

SECTION A: APPLICANT'S PERSONAL PARTICULARS																			
Facility's Y no:	Y					RP's P No.	P												
Surname/last name																			
Title				Initials (first names)															
First names in full																			
Identity number or Permit number																			
Date of birth			/									Gender and race	Male	Female	Race	Asian	Black	Coloured	White
Cell phone number																			
Work telephone number																			
Fax telephone number																			
E-mail address																			
Name of the Pharmacy																			
Courier address																			
											Street code								

SECTION B: APPLICABLE FEES (TICK IN THE APPROPRIATE BLOCK(S))					
Recording of a facility R2,542.00 (VAT incl)	Recording of a facility (Pre - may 2003) R2,542.00 (VAT incl)	Owner R2,542.00 (VAT incl)	Approval of a Pharmacy Premises for training purposes R2,542.00 (VAT incl)	Grading of a Pharmacy Certificate R2,542.00 (VAT incl)	Other R2,542.00 (VAT incl)

SECTION D: DECLARATION BY APPLICANT

I, the above applicant, declare that:

- I have not been found guilty of any offence under the Pharmacy Act, 1974, as amended; and
- The information furnished herewith is true and correct.

Applicant's Signature: _____ Application Date: DD / MM / YY YY

SECTION F: DECLARATION BY COMMISSIONER OF OATHS

The abovementioned was SIGNED and SWORN TO before me at
on this ____ day of _____ in the year _____, the deponent (applicant) having
acknowledged that he/she knows and understands the contents of this declaration.

STAMP
(Compulsory)

(Full names, capacity, address and contact details of Commissioner of Oaths)

SIGNATURE OF COMMISSIONER OF OATHS

SAPC Electronic Payment Details (if not yet captured on Council's financial system)

Name of Beneficiary	South African Pharmacy Council										
Name of Bank	Standard Bank of South Africa										
Account type	Cheque account										
Branch Code	0	1	0	1	4	5					
Beneficiary Account number	0	1	1	8	8	5	8	6	6		
Beneficiary Reference	Your account number ** with SAPC and surname & initials.										

PLEASE NOTE:

- This application is **valid for 60 days from date of receipt by the Office of the Registrar**. Should you fail to submit all the required supporting documentation and fees/proof of payment of fees within 60 days of this application the application will be invalid and all fees (excluding annual fee) that may have been paid herewith shall be forfeited.
- Cash, postal orders and cheques will not be accepted with any application form.
- South African Pharmacy Council has a policy of zero tolerance to fraud and corruption. All fraud and corruption cases detected or reported will be investigated and perpetrators will be prosecuted accordingly.

Signature _____

Date _____