



South African Pharmacy Council

591 Belvedere Street, Arcadia, Pretoria, 0083; Private Bag X40040, Arcadia, 0007; www.sapc.za.org
Tel: 0861 SAPC 00; Fax: 27 (12) 321 1479/92; E-mail: customer@sapc.za.org

Form is valid for
2024 only

CHANGE OF FACILITY FOR PERFORMANCE OF COMMUNITY PHARMACEUTICAL SERVICE 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		For office use only			
SECTION A: APPLICANT'S PERSONAL PARTICULARS					
Council registration number	<input style="width: 100px; height: 20px; border: 1px solid black;" type="text"/> Council account number P <input style="width: 100px; height: 20px; border: 1px solid black;" type="text"/>				
Role type:	<input style="width: 100%; border: 1px solid black;" type="text"/> Community Service Pharmacist				
Surname/last name	<input style="width: 100%; border: 1px solid black;" type="text"/>				
Title	<input style="width: 50px; border: 1px solid black;" type="text"/> Initials (first names) <input style="width: 50px; border: 1px solid black;" type="text"/>				
First names in full	<input style="width: 100%; border: 1px solid black;" type="text"/>				
Identity number or Permit number	<input style="width: 100px; border: 1px solid black;" type="text"/> - <input style="width: 100px; border: 1px solid black;" type="text"/> - <input style="width: 50px; border: 1px solid black;" type="text"/> - <input style="width: 50px; border: 1px solid black;" type="text"/>				
Date of birth	<input style="width: 30px; border: 1px solid black;" type="text"/> / <input style="width: 30px; border: 1px solid black;" type="text"/> / <input style="width: 40px; border: 1px solid black;" type="text"/>				
Gender and race (refer note A)	<input type="checkbox"/> Male <input type="checkbox"/> Female Race <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Coloured <input type="checkbox"/> White				
Postal address (Refer notes B and C)	<input style="width: 100%; border: 1px solid black;" type="text"/> <input style="width: 100%; border: 1px solid black;" type="text"/> Postal code				
Courier address (Refer notes B and C)	<input style="width: 100%; border: 1px solid black;" type="text"/> <input style="width: 100%; border: 1px solid black;" type="text"/> Postal code				
Cell number	<input style="width: 100%; border: 1px solid black;" type="text"/>				
Fax number	<input style="width: 100%; border: 1px solid black;" type="text"/>				
E-mail address	<input style="width: 100%; border: 1px solid black;" type="text"/>				
SECTION B: PARTICULARS OF THE PREVIOUS PHARMACY					
Name of pharmacy/institution approved for training	<input style="width: 100%; border: 1px solid black;" type="text"/>				
Pharmacy registration no:	<input style="width: 50px; border: 1px solid black;" type="text"/> Y <input style="width: 50px; border: 1px solid black;" type="text"/>				
Sector of pharmacy	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Private Sector</td> <td style="width: 50%; text-align: center;">Public Sector</td> </tr> </table>	Private Sector	Public Sector		
Private Sector	Public Sector				
Branch of pharmacy	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Institutional (hospital)</td> <td style="width: 50%; text-align: center;">Community</td> </tr> </table>	Institutional (hospital)	Community		
Institutional (hospital)	Community				
End date with pharmacy	<input style="width: 100%; border: 1px solid black;" type="text"/>				
SECTION C: PARTICULARS OF THE NEW PHARMACY					
Name of pharmacy/institution approved for training	<input style="width: 100%; border: 1px solid black;" type="text"/>				
Pharmacy registration no:	<input style="width: 50px; border: 1px solid black;" type="text"/> Y <input style="width: 50px; border: 1px solid black;" type="text"/>				
Physical address	<input style="width: 100%; border: 1px solid black;" type="text"/> <input style="width: 100%; border: 1px solid black;" type="text"/> Postal code				
Sector of pharmacy	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Private Sector</td> <td style="width: 50%; text-align: center;">Public Sector</td> </tr> <tr> <td style="width: 50%; text-align: center;">Institutional (hospital)</td> <td style="width: 50%; text-align: center;">Community</td> </tr> </table>	Private Sector	Public Sector	Institutional (hospital)	Community
Private Sector	Public Sector				
Institutional (hospital)	Community				
Start date with the new pharmacy	<input style="width: 100%; border: 1px solid black;" type="text"/>				

Signature _____

Date _____



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SECTION D: SUPPORTING DOCUMENTATION AND APPLICABLE FEES	
I, the above applicant, submit the following in support of my application:	Mark with a ✓
a) New employment contract	<input type="checkbox"/>
b) Fee for change of facility – community pharmacist: R1 193.00 (VAT incl.)	<input type="checkbox"/>
SECTION E: DECLARATION BY APPLICANT	
I, the above applicant, declare that:	
a) I herewith include all the applicable documentation/fees mentioned in Section D above;	
b) I comply with the requirements for registration as a community service pharmacist;	
c) I have not been found guilty of any offence under the Pharmacy Act, 1974, as amended; and	
d) The information furnished herewith is true and correct.	
Applicant's Signature: _____	Application Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION F: DECLARATION BY COMMISSIONER OF OATHS	
The abovementioned was SIGNED and SWORN TO before me at _____ (place)	<p align="center">STAMP (compulsory)</p> <p align="center"><i>(Full names, capacity, address and contact details of Commissioner of Oaths)</i></p>
on this ____ day of _____ in the year _____, the deponent (applicant) having acknowledge that he/she knows and understands the contents of this declaration.	
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
 - Your registration date will be determined by the date of receipt of a completed application form, supporting documents and fees (please refer to item 1. above)
 - 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 _____