



APPLICATION FOR ACCREDITATION/APPROVAL AS A PROVIDER OF A COURSE LEADING THE OCCUPATIONAL CERTIFICATE: PHARMACIST'S ASSISTANT (BASIC), OCCUPATIONAL CERTIFICATE: PHARMACIST'S ASSISTANT (POST BASIC) AND THE OCCUPATIONAL CERTIFICATE: PHARMACY TECHNICIAN

PARTICULARS OF THE APPLICANT

1. Name of prospective Provider (institution, organisation, person):

2. Postal address:

3. Physical address:

4. Responsible Person:

ALL CORRESPONDENCE TO BE ADDRESSED TO THE REGISTRAR



The South African Pharmacy Council

Form is valid for
2024 only

591 Belvedere Street, Arcadia, Pretoria, 0083; Private Bag X40040, Arcadia, 0007; www.sapc.za.org;
Tel: 0861 7272 00; Fax: 27 (12) 321 1479/92; E-mail: customercare@sapc.za.org

5. Contact details of Responsible Person:

Tel no.: _____
 Fax no.: _____
 Email address: _____

6. Shareholder information:

7. Enterprise size:

What is the enterprise size of the provider/business? *(Please supply evidence)*

	Tick appropriate box
Small provider (fewer than 50 employees)	<input type="checkbox"/>
Large provider (more than 50 employees)	<input type="checkbox"/>
Other (Elaborate below)	<input type="checkbox"/>

SUPPORTING DOCUMENTATION AND APPLICABLE FEES

I, the above applicant, submit the following in support of my application:

**Tick appropriate
box**

(a) an electronic copy of the application (including supporting evidence)

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- (b) a complete accreditation/monitoring visit instrument for Skills Development Providers
- (c) the fee for the evaluation of an application for purposes of approval as a provider (payable with application and including VAT):
 - Occupational Certificate: Pharmacist’s Assistant (Basic) **R111 862.00**
 - Occupational Certificate: Pharmacist’s Assistant (Post Basic) **R115 418.00**
 - Occupational Diploma Pharmacy Technician **R120 749.00**

(refer to notes below)

Note A: Please note that a registration fee of **R2, 679.00 (VAT incl.)** is payable following approval as a provider

Note B: Please note that an annual fee of **R34, 627.00 (VAT incl.)** is payable following approval as a provider

DECLARATION

I/We hereby declare that:

- (a) Any education and/or training offered in terms of the regulations relating to the education and training of pharmacy personnel will be carried out in accordance with the conditions determined by Council in such regulations and agree that any proposals or claims made in this application may be monitored at any time at the discretion of Council.
- (b) The information furnished herewith is true and correct.

Signature: _____

Name: _____

Designation: _____

Date of application: _____

PLEASE NOTE:

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1. Please request a proforma invoice for the fees payable.
2. This application is valid for **60 days** from the 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 shall be rendered void and all fees (excluding annual fee) that may have been paid herewith shall be forfeited.

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