



South African Pharmacy Council

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

Form is valid for
2026 only

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APPLICATION FOR A PHARMACIST INTERN TO PRACTICE AS A PHARMACIST'S ASSISTANT PHARMACY TECHNICIAN IN TERMS OF THE PHARMACY ACT, 53 OF 1974

(INTERNS WHO HAVE COMPLETED 365 DAYS BUT NOT YET COMPETENT IN THE PRE-REGISTRATION EVALUATION)

Please use black ink and complete in BLOCK CAPITALS. Return to: The Registrar, South African Pharmacy Council		PLEASE NOTE:
SECTION A: APPLICANT'S PERSONAL PARTICULARS		Note A: You are requested to furnish gender and race to enable Council to measure transformation in the profession.
P number	P <input type="text"/>	Note B: The postal address furnished herewith shall be deemed to be the applicant's registered address. All correspondence and certificates will be posted to this address.
Surname/last name	<input type="text"/>	Note C: A change of address must be submitted to the registrar within 30 days of such change.
Title	<input type="text"/> Initials (first names) <input type="text"/>	
First names in full	<input type="text"/>	
Identity number	<input type="text"/> - <input type="text"/> - <input type="text"/> - <input type="text"/>	
Date of birth	DD / MM / YYYY	
Gender and race (refer note A)	Male <input type="checkbox"/> Female <input type="checkbox"/> Race Asian <input type="checkbox"/> Black <input type="checkbox"/> Coloured <input type="checkbox"/> White <input type="checkbox"/>	
Postal address (refer notes B and C)	<input type="text"/> <input type="text"/> Postal code <input type="text"/>	
Physical address (refer note C)	<input type="text"/> <input type="text"/> Street code <input type="text"/>	
Cell number	<input type="text"/>	
Courier address	<input type="text"/> <input type="text"/> Code <input type="text"/>	
Work telephone number (If applicable)	(<input type="text"/>) <input type="text"/> - <input type="text"/>	
Fax number (If applicable)	(<input type="text"/>) <input type="text"/> - <input type="text"/>	
E-mail address	<input type="text"/>	
SECTION B: REASON FOR APPLICATION		
Internship contract terminated and not yet successful in the pre-registration examination		
SECTION C: SUPPORTING DOCUMENTATION AND APPLICABLE FEES		Note D: This approval is subject to the following: 1) the intern must have completed the period of at least 365 days practical internship under an approved tutor in an approved pharmacy premises 2) the intern's tutor must have submitted all the required progress reports 3) the intern must have submitted six CPD entries and been successful in all six CPD entries 4) the intern must be unsuccessful in the pre-registration examination.
I, the above applicant, submit the following in support of my application:	Mark with a ✓	
a) documentary evidence that my internship contract has been terminated by my tutor and/or employer and there is no option to extend the contract	<input type="checkbox"/>	
b) documentary evidence that I have applied for internship elsewhere and my application was turned down (evidence of application and response from two or more pharmacies);	<input type="checkbox"/>	
c) Annual fee: R 734.00.00 (VAT incl.) payable with application (refer note E)	<input type="checkbox"/>	Note E: Fees are subject to change without further notification.



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SECTION D: DECLARATION BY APPLICANT						
<p>I, the above applicant, declare that:</p> <p>(a) I herewith include all the applicable documentation/fees mentioned in Section C above;</p> <p>(b) I will comply with the requirements for practicing as a pharmacist's assistant (post-basic);</p> <p>(c) I have not been found guilty of any offence under the Pharmacy Act, 1974, as amended; and</p> <p>(d) the information furnished herewith is true and correct.</p> <p>Applicant's Signature: _____ Application Date: <table border="1" style="display: inline-table;"><tr><td>DD</td><td>/</td><td>MM</td><td>/</td><td>YYYY</td></tr></table></p>	DD	/	MM	/	YYYY	
DD	/	MM	/	YYYY		
SECTION E: DECLARATION BY COMMISSIONER OF OATHS						
<p>The abovementioned declarations were SIGNED and SWORN TO before me at</p> <p>_____</p> <p>(place)</p> <p>on this ____ day of _____ in the year _____, the deponents (applicant)</p> <p>having acknowledged that they know and understand the contents of this declaration.</p> <p>SIGNATURE OF COMMISSIONER OF OATHS _____</p>	<p style="text-align: center;">STAMP (Compulsory)</p> <p style="text-align: right; font-size: small;">(Full names, capacity, address and contact details of Commissioner of Oaths)</p>					

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:

1. 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
2. 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)
3. Cash, postal orders and cheques will not be accepted with any application form.
4. 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.