



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

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APPLICATION FOR THE CLOSURE OF A PHARMACY IN TERMS OF THE PHARMACY ACT 53 OF 1974

Please use b Return to: Th	lack ink and complete in BLOCK CAPITALS. ne Registrar, South African Pharmacy Council	Office Use Only			
PARTICULARS OF THE OWNER AND THE PHARMACY TO BE ERASED					
Pharmacy owner	Company Close Corporation Partnership Sole Proprietor Trust State				
Category of pharmacy	Community Institutional (private) Wholesale Manufacturing Consultant Institutional Public C1 C13 C8 C6 C14 C2				
Full name(s) of owner (company, close corporation, person etc.)	Phormagy account number by July 1				
Pharmacy account number Y					
Trading title of the pharmacy as recorded with Council?					
Pharmacy physical address (as recorded with Council)					
Pharmacy telephone number	(
Pharmacy fax number	(
Pharmacy e-mail address					
when was or is the pharmacy intending to cease trading					
PARTICULARS OF THE RESPONSIBLE PHARMACIST (RP)					
RP Reg Number	RP Account number (if available)				
Surname/Last Name					
Title	Initials (First Names)				
First Names In Full					
Cell number					
E-mail address					
Courier address					
Identity Number or					

F	\pplicant [*]	's signat	ture	Date



Form is valid for **2022** only

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Passport number					
REASONS FOR CLOSURE					
Choose one of the reasons below or specify the reason for closure a) Financial reasons b) Liquidation c) Pricing regulations d) Property sold e) No responsible pharmacist f) Owners request g) Others, please specify	Mark with a				
SUPPORTING DOCUMENTATION					
 I, the above applicant, submit the following in support of this application: a copy of the licence to own a pharmacy issued by the department of Health in terms of the Pharmacy Act 53 of 1974 as amended b) a list of all tutors, Interns and learners (each with his or her role type) that are currently practising in this facility; c) a legal document containing a list of shareholders, members, trustees etc, or a document signed by shareholders appointing you as a liaising personnel (except In case of a sole proprietorship). 	Mark with a ✓				
DECLARATION BY THE OWNER OR RP					
I. declare that: -					
a) I herewith include the applicable documentation;					
	any mambars				
b) I am the RP or sole owner of the pharmacy or have been empowered by the composition or trustees etc, to request the Council to close the above mentioned pharmacy.					
c) the information furnished herewith is true and correct.					
RP or Owners Signature: Date: DD / MM / YYYY					