South African Pharmacy Council
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Form is valid for **2023** only

APPLICATION FOR THE CLOSURE OF A PHARMACY 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

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 C1 | Institutional (private) C13 | Wholesale C8 | Manufacturing C6 | Consultant C14 | Institutional Public C2

Full name(s) of owner (company, close corporation, person etc.)

Pharmacy account number: Y

Trading title of the pharmacy as recorded with Council?

Pharmacy physical address **(as recorded with Council)**

Street code

Pharmacy telephone number ( ) -

Pharmacy fax number ( ) -

Pharmacy e-mail address

when was or is the pharmacy intending to cease trading: D D / M M / Y Y Y Y

PARTICULARS OF THE RESPONSIBLE PHARMACIST (RP)

RP Reg Number

RP Account number (if available): P

Surname/Last Name

Title

Initials (First Names)

First Names In Full

Cell number

E-mail address

Courier address

Code

Identity Number or

Applicant's signature_____ Date_____

Passport number

REASONS FOR CLOSURE

Choose one of the reasons below or specify the reason for closure

		Mark with a ✓
a)	Financial reasons	
b)	Liquidation	
c)	Pricing regulations	
d)	Property sold	
e)	No responsible pharmacist	
f)	Owners request	
g)	Others, please specify_____	

SUPPORTING DOCUMENTATION

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

		Mark with a ✓
a)	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) .	

DECLARATION BY THE OWNER OR RP

I, declare that: -

a) I herewith include the applicable documentation;

b) I am the RP or sole owner of the pharmacy or have been empowered by the company, members 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:** D D / M M / Y Y Y Y

Applicant's signature_____ Date_____