



**Health Professions Councils of Namibia**  
*P Bag 13387, Windhoek*  
*36/37 Schönlein Street, Windhoek West*  
**Telephone +264 61 245586 / 245928 / 247281 / 245052**  
**/ Fax +264 61 224549 / 271891**  
 e-mail address : [pc@hpcna.com.na](mailto:pc@hpcna.com.na)

**Pharmacy Council of Namibia**

Please complete this form in full.  
 Completed forms must be addressed to the Registrar.

**APPLICATION FOR RESTRUCTURING OF A PHARMACEUTICAL PRACTICE**

Name of Business \_\_\_\_\_  
 Trading as (if applicable) \_\_\_\_\_  
 Client #: \_\_\_\_\_

Ownership of Practice:

☐ Sole Owner      ☐ Private Company      ☐ Close Corporation      ☐ Hospital pharmacy

The Pharmaceutical Practice is doing business as:

*Community Pharmacy* ☐ / *Wholesale Pharmacist* ☐ / *Manufacturing Pharmacy* ☐ / *Private Hospital Pharmacy* ☐

Postal Address

|  |
|--|
|  |
|--|

Telephone

Office

Cell

|  |
|--|
|  |
|  |

Fax

e-mail

|  |
|--|
|  |
|  |

**Envisaged starting date of restructuring of pharmacy:** \_\_\_\_\_

**Envisaged completion date of restructuring of pharmacy:** \_\_\_\_\_

**Indicate the reason for restructuring of pharmacy:** \_\_\_\_\_

|  |
|--|
|  |
|  |
|  |

***The following documents (certified by a Commissioner of Oaths must accompany the application:***

1. Proof of citizenship of the Owner or Managing Director/ Member and Responsible Pharmacist (birth certificate ☐, passport ☐, identity document ☐, \*Certificate of Citizenship issued by Ministry of Home Affairs & Immigration (\*only in the case of Namibian citizens) applicant(s) ☐
2. Old Floor plan of the pharmacy drawn to scale. ☐
3. New Floor plan of the pharmacy drawn to scale with exact measurements indicating the changes. ☐
4. Floor plan of the building/complex indicating the pharmacy (drawn to scale). ☐
5. Copy of lease agreement or sale agreement for the premises. ☐
6. Application fee: N\$ 3,740.00 Namibian-owned community pharmacy and N\$ 14,960.00 for non-citizen owned community pharmacy; N\$ 6,860.00 for hospital pharmacies; and N\$ 8,600.00 for wholesale pharmacists. ☐

**PARTICULARS OF RESPONSIBLE PHARMACIST**

Responsible Pharmacist Name: \_\_\_\_\_ Client #: \_\_\_\_\_  
HPCNA Registration Date: \_\_\_\_\_ Duration in practise: \_\_\_\_\_  
(MARK WITH X) APPLICANT HPCNA  
Date when the Responsible Pharmacist was appointment: \_\_\_\_\_

\_\_\_\_\_  
Signature of Responsible Pharmacist

\_\_\_\_\_  
Date

**REQUIREMENTS: PREMISES OF A PHARMACY PRACTICE**

The total floor area of the pharmacy premises is \_\_\_\_\_ m<sup>2</sup>. ☐

The total dispensing area is \_\_\_\_\_ m<sup>2</sup>. ☐

The working surface with impervious covering with free working space is \_\_\_\_\_ m<sup>2</sup>. ☐

Stainless steel or similarly impervious basin with running hot and cold water ☐

Semi private consultation at the dispensing counter ☐

Separate secluded private consultation area ☐

Area for manufacturing or compounding of medicine is at least \_\_\_\_\_ m<sup>2</sup> ☐

Storage areas secured against unauthorised entry ☐

Veterinary medicines stored separate from human medicines ☐

Waiting area with suitable seating facilities for \_\_\_\_\_ patients ☐

Receiving area with sufficient space ☐

Kitchen provided for staff ☐

Toilet facilities provided for staff ☐

Lighting in the pharmacy: \_\_\_\_\_ ☐

Air conditioners; Type \_\_\_\_\_; Amount \_\_\_\_\_ ☐

Security system; \_\_\_\_\_ ☐

## EQUIPMENT APPLIANCES AND PUBLICATIONS TO BE PROVIDED IN A PHARMACEUTICAL PRACTICE

- |   |                          |
|---|--------------------------|
| (a) A refrigerator for thermolabile medicine  | <input type="checkbox"/> |
| (b) Separate refrigerator for veterinary medicines  | <input type="checkbox"/> |
| (c) Separate refrigerator for the staff   | <input type="checkbox"/> |
| (d) Standby generator or other emergency power  | <input type="checkbox"/> |
| (e) Thermometers and temperature recording sheet available  | <input type="checkbox"/> |
| (f) Lockable safe or cupboard for the storage of Schedule 4 substances;   | <input type="checkbox"/> |
| (g) A dispensing balance or digital scale that is calibrated annually;  | <input type="checkbox"/> |
| (h) Standard Operating Procedures (SOP's) as stipulated in Regulation No 101 of 25 July 2014 to be available on inspection.                                   | <input type="checkbox"/> |
| (i) The following dispensing measures:  |                          |
| (i) one x 200 ml measure;   | <input type="checkbox"/> |
| (ii) one X 100 ml measure;  | <input type="checkbox"/> |
| (iii) one x 10 ml measure;  | <input type="checkbox"/> |
| (iv) one x 5 ml measure or graduated pipette;   | <input type="checkbox"/> |
| (v) a funnel;   | <input type="checkbox"/> |
| (vi) two mortars and pestles (one, at least, of glass);   | <input type="checkbox"/> |
| (vii) a stirring rod;   | <input type="checkbox"/> |
| (viii) two spatulas;  | <input type="checkbox"/> |
| (ix) an ointment slab;  | <input type="checkbox"/> |
| (x) a tablet counting tray.   | <input type="checkbox"/> |
| (j) Publications and Reference Material as stipulated in Regulation No 101 of 25 July 2014;   |                          |
| (i) The Pharmacy Act, 2004 (Act No. 9 of 2004) and the regulations and rules made or published under that Act,  | <input type="checkbox"/> |
| (ii) The Medicines and Related Substances Control Act, 2003 (Act No. 13 of 2003), and the regulations or government notices made or published under that Act, | <input type="checkbox"/> |
| (iii) The latest available last editions of the pharmacopoeia,  | <input type="checkbox"/> |
| (iv) A handbook on toxicology and poisoning,  | <input type="checkbox"/> |
| (v) A handbook on pharmacology, as determined by the Council,   | <input type="checkbox"/> |
| (vi) Brochures and other informative material on the proper use of medication and on other health related matters as the Council may determine,               | <input type="checkbox"/> |
| k) The latest Namibia Guidelines as published by the Ministry of Health and Social Services Including;  |                          |
| (i) The Namibia Standard Treatment Guidelines,  | <input type="checkbox"/> |
| (ii) HIV Guidelines,  | <input type="checkbox"/> |
| (iii) Malaria Guidelines,   | <input type="checkbox"/> |
| (iv) TB Guidelines.   | <input type="checkbox"/> |

---

### STATEMENT BY MANAGING MEMBER/DIRECTOR

I (full names)\_\_\_\_\_ hereby declare that I have accepted the position of managing member/director of the abovementioned Close Corporation/Private Company. I further declare that I am a registered pharmacist residing in Namibia and that I am not engaged in the business of a pharmacist which does not belong to the said Close Corporation / Private Company.

\_\_\_\_\_  
Signature of Managing Director/Member

\_\_\_\_\_  
Date

I declare under oath/solemnly affirm that the information provided above is true, correct and complete.

\_\_\_\_\_  
Signature and capacity

\_\_\_\_\_  
Date

Sworn / solemnly affirmed before me at \_\_\_\_\_ this  
\_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

\_\_\_\_\_  
Name

Official stamp

\_\_\_\_\_  
Signature  
*Commissioner of Oaths*

**FOR OFFICIAL USE**

☐ Fee(s) payable

☐ Application fee for relocation

N\$ \_\_\_\_\_ paid

☐ **Total amount paid**

N\$ \_\_\_\_\_ paid

☐ Account paid in/by

☐ Bank deposit / Electronic transfer

☐ Swipe

\_\_\_\_\_  
**Administrative Officer**

\_\_\_\_\_  
Date

Comments/Remarks by the Assistant Council Manager

\_\_\_\_\_  
Verified & Recommended: Assistant Council Manager

\_\_\_\_\_  
Date

Comments/Remarks by Council Manager

\_\_\_\_\_  
Council Manager

\_\_\_\_\_  
Date

**Certificate may be released.**

\_\_\_\_\_  
Registrar

\_\_\_\_\_  
Date