



**Health Professions Councils of Namibia**  
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**Pharmacy Council of Namibia**

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

Client #: \_\_\_\_\_

## SECTION A

### APPLICATION FOR REGISTRATION OF A BUSINESS AS A WHOLESALE PHARMACIST

Name of Business \_\_\_\_\_

Trading as (if applicable) \_\_\_\_\_

Ownership of Wholesale Pharmacist:

Private Company       Public Company

Postal Address

Telephone    Office  
                   Cell


Fax  
 e-mail


Physical address (*Indicate Street name & number, suburb, town/city*)

Envisaged opening date of the business of a wholesale pharmacist (new business): \_\_\_\_\_

Envisaged opening date of the business of a wholesale pharmacist (existing business): \_\_\_\_\_

**The following documents (copies must be certified by a Commissioner of Oaths) must accompany the application (tick in the box under applicant for submitted documents):**

	<b>Applicant</b>	<b>HPCNA</b>
1. Floor plan of the business drawn to scale by an architect showing the actual layout and exact measurements of the areas.	<input type="checkbox"/>	<input type="checkbox"/>
2. Floor plan of the building/complex showing the location of the business premises in relation to adjoining or surrounding business premises. (Drawn to scale).	<input type="checkbox"/>	<input type="checkbox"/>
3. Certified copy of the Memorandum of Association.	<input type="checkbox"/>	<input type="checkbox"/>
4. Certified Copy of the signed lease agreement or sale agreement for the premises. (The lease agreement or sales agreement must be in the name of the company)	<input type="checkbox"/>	<input type="checkbox"/>
5. A statement setting out the following information about each person who holds a proprietary interest in the conducting business as wholesale pharmacist.		
(i) The name, postal and physical address of each person;	<input type="checkbox"/>	<input type="checkbox"/>
(ii) The nature and extent of the interest held by each person;	<input type="checkbox"/>	<input type="checkbox"/>
(iii) A telephone number and email address of each person;	<input type="checkbox"/>	<input type="checkbox"/>
(iv) Details of any proprietary interest the person holds in any other business as a wholesale pharmacist, including the nature and extent of the person's interest in that business, the name and address of such other business, and the names and addresses of every other person who holds a proprietary interest in that other business;	<input type="checkbox"/>	<input type="checkbox"/>
6. A statement setting out the standard operating procedures to be applied at the business as a wholesale pharmacist in relation to the -		
(i) procurement of medicine;	<input type="checkbox"/>	<input type="checkbox"/>
(ii) receipt and storage of medicine, including the monitoring of expiry dates and temperature control of the medicines;	<input type="checkbox"/>	<input type="checkbox"/>
(iii) dispatch of medicines;	<input type="checkbox"/>	<input type="checkbox"/>
(iv) control of documents;	<input type="checkbox"/>	<input type="checkbox"/>
(v) security and access control; and	<input type="checkbox"/>	<input type="checkbox"/>
(vi) measures to be applied in respect of a refrigerator, air conditioner or any other area where medicines are stored, if there is a power failure	<input type="checkbox"/>	<input type="checkbox"/>
7. N\$ 8,600.00 Application fee for registration as a Wholesale Pharmacist.	<input type="checkbox"/>	<input type="checkbox"/>
8. N\$220 x 3 for issuing of Business, Managing Director and Responsible Pharmacists Certificates.	<input type="checkbox"/>	<input type="checkbox"/>

### DETAILS OF THE MANAGING DIRECTOR

Name and Surname: \_\_\_\_\_ Client #: \_\_\_\_\_  
HPCNA Registration **Date:** \_\_\_\_\_ Duration in practise: \_\_\_\_\_  
Namibian identity document number: \_\_\_\_\_   
Permanent resident of Namibia    
Proof and Nature of current employment \_\_\_\_\_

### SECTION B

#### DETAILS OF RESPONSIBLE PHARMACIST

Name and Surname: \_\_\_\_\_ Client #: \_\_\_\_\_  
HPCNA Registration Date: \_\_\_\_\_ Duration in Practice: \_\_\_\_\_  
Proof of citizenship: Country: \_\_\_\_\_ Identity Document  Passport ,  
Date of appointment as the Responsible Pharmacist: \_\_\_\_\_  
Date on which active duty as the Responsible Pharmacist will commence: \_\_\_\_\_    
Letter of appointment of the Responsible Pharmacist    
Letter of acceptance of that appointment by the Responsible Pharmacist

Proof and Nature of current employment \_\_\_\_\_

Letter of resignation from the previous pharmaceutical practice (if any).

Certified copy of the work visa. (If Responsible Pharmacist is a non-Namibian)

**AFFIDAVIT /STATEMENT BY RESPONSIBLE PHARMACIST**

I (Full names) \_\_\_\_\_ hereby declare that I have accepted the position of responsible pharmacist of the abovementioned business.

I further declare that I am a registered pharmacist residing in Namibia.

I am not practicing in other business of a pharmacist which does not belong to the said Company.

I am currently practicing in the business of a pharmacist which does not belong to the said Company and will resign upon approval of the business as wholesale pharmacist.

*(Please deleted a) or b) if not applicable)*

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

\_\_\_\_\_  
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*

**SECTION C**

**REQUIREMENTS TO CONDUCT A BUSINESS AS A WHOLESALE PHARMACIST**

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

The business is secured against unauthorised entry.

Secure Access restricted to Authorised personnel only.

An effective manual or digital system to control medicines.

Tracing system for purchase of medicines

Sufficient shelving with smooth washable and impermeable material

Adequate Pallets for Bulk Stock suitably placed to allow cleaning

A clearly demarcated separate receiving area, shielded from adverse weather conditions, with direct access for delivery vehicles;

A clearly demarcated dispatch area, separate from the receiving area with direct access to

delivery vehicles and is shielded from adverse weather conditions.	<input type="checkbox"/>	<input type="checkbox"/>
Separate storage spaces for medicines used by human beings	<input type="checkbox"/>	<input type="checkbox"/>
Separate storage spaces for veterinary medicines	<input type="checkbox"/>	<input type="checkbox"/>
A record keeping system of all disposed medicines;	<input type="checkbox"/>	<input type="checkbox"/>
Adequate cold storage with calibrated temperature monitoring devices for storing and receiving of thermolabile medicines for use by human beings.	<input type="checkbox"/>	<input type="checkbox"/>
Adequate cold storage with calibrated temperature monitoring devices for storing and receiving of thermolabile medicines for veterinary medicines.	<input type="checkbox"/>	<input type="checkbox"/>
A freezer for vaccines and medicines.	<input type="checkbox"/>	<input type="checkbox"/>
An automatic standby generator or an emergency power system in case of power failure <i>(All fridges and freezer must be connected to an automatic Standby generator or such power system)</i>	<input type="checkbox"/>	<input type="checkbox"/>
Rest room for staff	<input type="checkbox"/>	<input type="checkbox"/>
Kitchen for staff	<input type="checkbox"/>	<input type="checkbox"/>
Toilet facility for staff with adequate hand washing facilities	<input type="checkbox"/>	<input type="checkbox"/>
Secured designated area for the storage of Psychotic medicines or/and Narcotics substances;	<input type="checkbox"/>	<input type="checkbox"/>
Special and segregated areas for storage of Flammable and Explosive substances.	<input type="checkbox"/>	<input type="checkbox"/>
Storage area for cleaning materials.	<input type="checkbox"/>	<input type="checkbox"/>
Physically segregated storage areas for:		
(i) Rejected medicines,	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Expired medicines,	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Recalled medicines,	<input type="checkbox"/>	<input type="checkbox"/>
(iv) Returned medicines	<input type="checkbox"/>	<input type="checkbox"/>
(v) Suspected counterfeits;	<input type="checkbox"/>	<input type="checkbox"/>
Transportation system of medicines which prevent exposure of the medicines to conditions that could affect their stability, packaging integrity and to prevent contamination.	<input type="checkbox"/>	<input type="checkbox"/>
Washable and durable floor finish which can withstand movement of heavy loads.	<input type="checkbox"/>	<input type="checkbox"/>
Lighting in the business: _____		
Ventilation with Air conditioners; Type _____; Amount _____		
Security system; _____		

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**PUBLICATIONS, SOP'S AND PROCEDURES TO BE PROVIDED IN THE BUSINESS AS A WHOLESALE PHARMACIST**

The Pharmacy Act, 2004 (Act No.9 of 2004), the regulations, rules and notices made or published under the Act	<input type="checkbox"/>	<input type="checkbox"/>
The Medicines and Related Substances Control Act, 2003 (Act No. 13 of 2003) and the regulations or government notices made or published under the Act.	<input type="checkbox"/>	<input type="checkbox"/>
The latest editions of the relevant international extra pharmacopoeia.	<input type="checkbox"/>	<input type="checkbox"/>
A handbook on toxicology and poisoning.	<input type="checkbox"/>	<input type="checkbox"/>
A handbook on pharmacology.	<input type="checkbox"/>	<input type="checkbox"/>
Standard Operating Procedures on:		
(i) procurement of medicines.	<input type="checkbox"/>	<input type="checkbox"/>
(ii) receipt and storage of medicines, including the monitoring of expiry dates and temperature control of the medicines.	<input type="checkbox"/>	<input type="checkbox"/>
(iii) dispatch of medicines.	<input type="checkbox"/>	<input type="checkbox"/>
(iv) control of documents.	<input type="checkbox"/>	<input type="checkbox"/>
(v) security and access control.	<input type="checkbox"/>	<input type="checkbox"/>
(vi) measures to be applied in respect of a refrigerator, air conditioner or any other area where medicines are stored, if there is a power failure.	<input type="checkbox"/>	<input type="checkbox"/>
Additional safety and security measures for combustible liquids, solid and pressurised gases.	<input type="checkbox"/>	<input type="checkbox"/>

- A procedure on handling/instructions for medicines requiring special storage when selling and dispatching the medicines.
- A procedure including monitoring of medicines to be stored according to the manufacturer's recommended storage conditions.
- A procedure for returned medicines to be placed under quarantine and returned after the approval and quality evaluation by a responsible pharmacist.
- A reconciliation of medicines to be performed at least twice a year, comparing the actual and recorded product quantities.
- A procedure for the removal of expired medicines and storage in a designated area for destruction by incineration or the return of the expired medicines to the supplier.

**SECTION D**

**AFFIDAVIT /STATEMENT BY MANAGING DIRECTOR**

I (Full names) \_\_\_\_\_ hereby declare that I have accepted the position of managing director of the abovementioned business.  
 I further declare that I am a registered pharmacist residing in Namibia and that I am not practicing as Pharmacist in the business which does not belong to the said Company.

\_\_\_\_\_  
 Signature of Managing Director

\_\_\_\_\_  
 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*

\_\_\_\_\_  
 Name (Applicant)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature (Applicant)

\_\_\_\_\_  
 Date