Initials and Date of Receipt

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**

Enquiries: Ms ME Mathe and Mr M Buys

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

APPLICATION FOR CHANGE OF NAME 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 ☐ / *Wholesaler* ☐ / *Manufacturing Pharmacy* ☐ / *Private Hospital Pharmacy* ☐

Hereby notify the Registrar of the change in name from;

CHANGE FROM

PARTICULARS CURRENT NAME

Name: (Sole Owner) _____
Client #: _____
HPCNA Registration Date: _____

Name (Close Corporation/Private Company)_____
Trading as (if applicable) _____
Client #: _____

Postal Address	

Telephone	Office		Fax	
	Cell		e-mail	

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

CHANGE TO

PARTICULARS NEW NAME

New Name: (Sole Owner) _____
Client #: _____

New Name (Close Corporation/Private Company)_____
Trading as (if applicable) _____

Postal Address				
Telephone	Office		Fax	
	Cell		e-mail	

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

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. Copy of the New Memorandum of Association or Founding Statement. ☐
3. The names and addresses of every other person who holds a proprietary interest in the pharmaceutical practice. ☐
4. N$420 Application fee for Change in Name. ☐
5. N$200 x 3 for issuing of Certificates. ☐

PARTICULARS OF RESPONSIBLE PHARMACIST WHO WILL MANAGE THE PRACTICE

Responsible Pharmacist Name:_____ Client #: _____
HPCNA Registration Date: _____ Duration in practise:_____

(**MARK WITH X**)	**APPLICANT**	**HPCNA**
Letter of appointment of the Responsible Pharmacist	☐	☐
Letter of acceptance of that appointment by the Responsible Pharmacist	☐	☐

Date from which the appointment of the Responsible Pharmacist commenced:_____

_____ _____
Signature of Responsible Pharmacist Date

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 change of name N$_____ paid / not paid
- ☐ Printing of Certificates 190 x ☐ N$_____ paid / not paid
- ☐ **Total amount paid** **N$** _____

☐ Account paid in/by

- ☐ Bank deposit / Electronic transfer
- ☐ Swipe

_____ _____
Data Entry Clerk 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