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 REGISTRATION AS A RESPONSIBLE PHARMACIST

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* ☐

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☐, Permanent resident of Namibia☐.
2. Certified copy of the work visa. (if Responsible Pharmacist is a non-Namibian) ☐
3. Affidavit as responsible pharmacist in terms of the Pharmacy Act, 2004 (ACT NO 9 of 2004)
4. Letter of acceptance of that appointment by the Responsible Pharmacist ☐
5. Letter of resignation from the previous pharmaceutical practice. ☐
6. A non-refundable application for registration fee of N$570-00 ☐
7. N$200 for issuing of Certificates. ☐

STATEMENT BY SOLE OWNER/MANAGING MEMBER/DIRECTOR

I (full names) _____ hereby declare that I have appointed _____ as the Responsible Pharmacist of the abovementioned pharmaceutical practice effective as of_____(Date).

_____ _____
Signature of Managing Director/Member Date

PARTICULARS OF RESPONSIBLE PHARMACIST

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

Date on which active duty as the Responsible Pharmacist will commence: _____.

_____ _____
Signature of Responsible Pharmacist Date

Remarks_____
_____
_____
_____
_____

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	N$ 570-00
☐ Issuing of certificate	N$ 200-00
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