Health Professions Councils of Namibia
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Enquiries: Ms ME Mathe and Mr M Buys

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

Client #: ____________

APPLICATION FOR REGISTRATION OF A PHARMACEUTICAL PRACTICE

Name of Business____
Trading as (if applicable) ____
Alternative Trading Title: ____

Ownership of Practice:
☐ Sole Owner ☐ Private Company ☐ Close Corporation ☐ Hospital pharmacy

The Pharmaceutical Practice will do 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*)	

Envisaged opening date of pharmacy: ___________________________

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

1. Proof of citizenship, Permanent resident of Namibia☐, birth certificate☐, passport☐, identity document☐, Certificate of Citizenship issued by Ministry of Home Affairs & Immigration☐
2. Floor plan of the pharmacy drawn to scale. ☐
3. Floor plan of the building/complex indicating the pharmacy (drawn to scale). ☐
4. Copy of the signed lease agreement or sale agreement for the premises. ☐
5. Copy of partnership agreement. ☐
6. Copy of the Memorandum of Association or Founding Statement. ☐
7. Details of any proprietary interest members hold in any other pharmaceutical practice. ☐

Name of Business	Name of Managing Director/ Member of Business	Name of Responsible Pharmacist

8. The names and addresses of every other person who holds a proprietary interest in that other pharmaceutical practice. ☐
9. A copy of the current registration certificate issued in relation to the private hospital under the Hospitals and Health Facilities Act, 1994 (Act No. 36 of 1994). ☐
10. A statement setting out the following information about each person who holds a proprietary interest in the hospital pharmacy that is to be carried on in the private hospital;
    (i) The name and address of each person; ☐
    (ii) The nature and extent of the interest held by each person; ☐
    (ii) A telephone number and email address of each person; ☐
    (iv) Details of any proprietary interest each person holds in any other pharmacy practice, including the nature and extent of the person's interest in such other pharmacy practice; ☐
    (v) The name and address of such other pharmacy practice, ☐
    (viii) The names and addresses of every other person who holds a proprietary interest in that other pharmacy practice. ☐
11. A copy of the agreement between persons who hold a proprietary interest in the pharmacy practice that makes provision for any rights the persons possess by virtue of having the proprietary interests; ☐
12. N$3430.00 Application fee for a Community Pharmacy / Private Hospital Pharmacy. ☐
13. N$4300.00 Application fee for a Wholesale Pharmacy. ☐
14. N$200 x 3 for issuing of Certificates. ☐

ELIGIBILITY FOR REGISTRATION OF A PHARMACY PRACTICE

Sole owner Name: ______________________________ Client #: ___________
HPCNA Registration **Date**: ____________________ Duration in practise: ______________

Managing Director ______________________________ Client #: ___________
HPCNA Registration **Date**: ____________________ Duration in practise: ______________
Interest in other Proprietary: ____

Managing Member ______________________________ Client #: ___________
HPCNA Registration **Date**: ____________________ Duration in practise: ______________
Interest in other Proprietary: ____

Member ______________________________ Client #: ___________
HPCNA Registration **Date**: ____________________ Duration in practise: ______________

APPOINTMENT OF RESPONSIBLE PHARMACIST

Responsible Pharmacist Name: ____________________________________ Client #: ____________
HPCNA Registration Date: ______________________ Duration in Practice: _________________
Date of appointment as the Responsible Pharmacist: _______________________.
Date on which active duty as the Responsible Pharmacist will commence: _______________________.

(MARK WITH X)	APPLICANT	HPCNA
Letter of appointment of the Responsible Pharmacist	☐	☐
Letter of acceptance of that appointment by the Responsible Pharmacist	☐	☐
Letter of resignation from the previous pharmaceutical practice.		☐
Certified copy of the work visa. (if Responsible Pharmacist is a Non-Namibian)		☐
Affidavit as responsible pharmacist in terms of the Pharmacy Act, 2004 (ACT NO 9 of 2004)		☐

_________________________________ __________
Signature of Responsible Pharmacist Date

REQUIREMENTS: PREMISES OF A PHARMACY PRACTICE

	APPLICANT	HPCNA
The total floor area of the pharmacy premises is ______m^2.		☐
The total dispensing area is ______m^2.		☐
The working surface with impervious covering with free working space is ______m^2.		☐
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^2		☐
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 ☐
(b) Separate refrigerator for veterinary medicines ☐
(c) Separate refrigerator for the staff ☐
(d) Standby generator or other emergency power ☐
(e) Thermometers and temperature recording sheet available ☐
(f) Lockable safe or cupboard for the storage of Schedule 4 substances; ☐
(g) A dispensing balance or digital scale that is calibrated annually; ☐
(h) Standard Operating Procedures (SOP's) as stipulated in Regulation No 101 of 25 July 2014 to be available on inspection. ☐
(i) The following dispensing measures:
    (i) one x 200 ml measure; ☐
    (ii) one X 100 ml measure; ☐

(iii) one x 10 ml measure; ☐
(iv) one x 5 ml measure or graduated pipette; ☐
(v) a funnel; ☐
(vi) two mortars and pestles (one, at least, of glass); ☐
(vii) a stirring rod; ☐
(viii) two spatulas; ☐
(ix) an ointment slab; ☐
(x) a tablet counting tray. ☐

(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, ☐
(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, ☐
(iii) The latest available last editions of the pharmacopoeia, ☐
(iv) A handbook on toxicology and poisoning, ☐
(v) A handbook on pharmacology, as determined by the Council, ☐
(vi) Brochures and other informative material on the proper use of medication and on other health related matters as the Council may determine, ☐

k) The latest Namibia Guidelines as published by the Ministry of Health and Social Services Including;
(i) The Namibia Standard Treatment Guidelines, ☐
(ii) HIV Guidelines, ☐
(iii) Malaria Guidelines, ☐
(iv) TB Guidelines. ☐

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

☐ Fees payable

- ☐ Application fee for new practice N$__________ paid / not paid
- ☐ Printing of Certificates 200 x ☐ N$__________ 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

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____

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Verified & Recommended: Assistant Council Manager Date _____________

Comments/Remarks by Council Manager

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____________________ ____________________

Council Manager Date

Certificate may be released

____________________ ____________________

Registrar Date