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
Email address: **pc@hpcna.com.na**

Pharmacy Council of Namibia

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

APPLICATION FOR CHANGE OF OWNERSHIP/MEMBERS OF A PHARMACEUTICAL PRACTICE

PARTICULARS OF CURRENT OWNER

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

Name of Business_____
Trading as (if applicable) _____
Client #: _____

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*)				

Name of Managing Member/Director/ Sole owner:_____
Client #: _____
Hereby solemnly affirm that the above entity was sold/transferred to:
_____

_____ _____
Signature of Managing Director/Member/Sole Owner Date

PARTICULARS OF NEW OWNER

New Client #: _____

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

Name of Sole Owner:_____
Name of Business:_____
Trading as (if applicable): _____

New Close Corporation/Private Company Yes ☐ No ☐ (Please note point 7 under the documents that must accompany the application)

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☐, *Permanent Residence☐
2. Copy of the New Memorandum of Association or Founding Statement. ☐
3. Copy of the lease agreement or sale agreement for the premises in the name of the new Owners. Company or Close Corporation.
4. A deed of sale or resolution indicating that the pharmacy has been sold/transferred ☐
5. The names and addresses of every other person who holds a proprietary interest in the pharmaceutical practice. ☐
6. Non-refundable application fee: change of ownership in community pharmacy: N$ 460.00 (Already registered CC or company) ☐
7. Non-refundable application fee: change of ownership of hospital pharmacy of wholesale pharmacist: N$ 840.00 (Already registered CC or company)
8. Non-refundable application fee for registration of new CC or company to conduct business as a: community pharmacist N$ N$3,740.00; hospital pharmacist N$ 6,860.00; wholesale pharmacist N$ N$8,600.00; ☐
9. N$220 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	☐	☐
Letter of resignation from the previous pharmaceutical practice.		☐
Affidavit as responsible pharmacist in terms of the Pharmacy Act, 2004 (ACT NO 9 of 2004)		☐

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

_____ _____
Signature of Responsible Pharmacist Date

STATEMENT BY NEW 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

STATEMENT BY NEW OWNER

I (full names) _____ hereby declare that I have accepted the position as owner of abovementioned entity.
I further declare that I am a registered pharmacist residing in Namibia.

_____ _____
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 Managing Director/Member/Sole Owner Date

Sworn / solemnly affirmed before me at _____ this _____ day of _____ 20_____

_____
Name

_____
Official stamp Signature
Commissioner of Oaths