



Health Professions Councils of Namibia
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Pharmacy Council of Namibia

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 / Wholesale Pharmacist / 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

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Telephone Office
 Cell

Fax
 e-mail

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

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CHANGE TO

PARTICULARS NEW NAME

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

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

Postal Address

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Telephone	Office		Fax	
	Cell		e-mail	

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

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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. Application fee: Community pharmacy N\$460.00; hospital pharmacy or wholesale pharmacist: N\$ 840.00.
- 5. Certificate fee: Namibians N\$ 220.00; non-citizens: N\$ 880.00

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
- Printing of Certificates N\$ _____ paid
- Total amount paid** N\$ _____

Account paid in/by

- Bank deposit / Electronic transfer
- Swipe

Administrative Officer

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

