



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

Pharmacy Council of Namibia

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

APPLICATION FOR RESTRUCTURING 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* / *Manufacturing Pharmacy* / *Private Hospital Pharmacy*

Postal Address

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Telephone	Office		Fax	
	Cell		e-mail	

Envisaged starting date of restructuring of pharmacy: _____

Envisaged completion date of restructuring of pharmacy: _____

Indicate the reason for restructuring of pharmacy: _____

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. Old Floor plan of the pharmacy drawn to scale.
3. New Floor plan of the pharmacy drawn to scale with exact measurements indicating the changes.
4. Floor plan of the building/complex indicating the pharmacy (drawn to scale).
5. Copy of lease agreement or sale agreement for the premises.
6. Application fee: N\$ 3,740.00 Namibian-owned community pharmacy and N\$ 14,960.00 for non-citizen owned community pharmacy; N\$ 6,860.00 for hospital pharmacies; and N\$ 8,600.00 for wholesale pharmacists.

PARTICULARS OF RESPONSIBLE PHARMACIST

Responsible Pharmacist Name: _____ Client #: _____
 HPCNA Registration Date: _____ Duration in practise: _____
(MARK WITH X) APPLICANT HPCNA
 Date when the Responsible Pharmacist was appointment: _____

 Signature of Responsible Pharmacist _____
 Date

REQUIREMENTS: PREMISES OF A PHARMACY PRACTICE

- | | | |
|--|--------------------------|--------------------------|
| The total floor area of the pharmacy premises is _____ m ² . | <input type="checkbox"/> | <input type="checkbox"/> |
| The total dispensing area is _____ m ² . | <input type="checkbox"/> | <input type="checkbox"/> |
| The working surface with impervious covering with free working space is _____ m ² . | <input type="checkbox"/> | <input type="checkbox"/> |
| Stainless steel or similarly impervious basin with running hot and cold water | <input type="checkbox"/> | <input type="checkbox"/> |
| Semi private consultation at the dispensing counter | <input type="checkbox"/> | <input type="checkbox"/> |
| Separate secluded private consultation area | <input type="checkbox"/> | <input type="checkbox"/> |
| Area for manufacturing or compounding of medicine is at least _____ m ² | <input type="checkbox"/> | <input type="checkbox"/> |
| Storage areas secured against unauthorised entry | <input type="checkbox"/> | <input type="checkbox"/> |
| Veterinary medicines stored separate from human medicines | <input type="checkbox"/> | <input type="checkbox"/> |
| Waiting area with suitable seating facilities for _____ patients | <input type="checkbox"/> | <input type="checkbox"/> |
| Receiving area with sufficient space | <input type="checkbox"/> | <input type="checkbox"/> |
| Kitchen provided for staff | <input type="checkbox"/> | <input type="checkbox"/> |
| Toilet facilities provided for staff | <input type="checkbox"/> | <input type="checkbox"/> |
| 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

Fee(s) payable

Application fee for relocation

N\$ _____ paid

Total amount paid

N\$ _____ paid

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