health
Department:
Health
REPUBLIC OF SOUTH AFRICA

APPLICATION FOR REPRINT OF PHARMACY LICENCE

Please return to: Licensing Unit,
AB Xuma Building, 112 Voortrekker Road, Pretoria Townlands 351-Jr, Pretoria, 0187
Contacts Us: 012 395 8201, 8202, 8203, 8204, 8205
Email to: pharmapps@health.gov.za

LU-FORM-5.3.1
Version 3
2024

DOH LICENCE NUMBER (where applicable)			
RECORDED PHARMACY NAME		**Y-Number**	
RECORDED PHARMACY OWNER			

*SECTION A: PHARMACY PARTICULARS

Pharmacy Owner	Company	Close Corporation	Partnership	Sole Proprietor	Trust	State	
Pharmacy Category	Community	Institutional (private)	Institutional (public)	Wholesale	Manufacturing	Consultant	
Name of Owner(s) as per CIPC registration (where applicable)							
CIPC Number (where applicable)							
Name of Owner(s) In case of sole proprietor or partnership							
ID number(s) In case of sole proprietor or partnership							
Physical Address							
						Code	
Postal Address (To which licence must be sent)							
						Code	
Telephone Number							
Fax Number							
Email Address							

*SECTION B: REASON FOR REPRINT

*SECTION C: SUPPORTING DOCUMENTS AND APPLICABLE FEES

I, above applicant, submit the following documents in support of this application:	Mark with X
(a) Certified copy of current licence issued by the National Department of Health (where applicable)	
(b) Proof of payment of licence reprint fee – R250	
(c) Certified copy of current pharmacy recording certificate of Pharmacy Owner and Responsible Pharmacist with the SAPC	
(d) Certified copy of licence issued by the Medicines Control Council (where applicable)	
(e) Copy of company registration documents with the Companies and Intellectual Property Commission (CIPC)	

National Department of Health Banking Details:

Bank	:	ABSA
Branch	:	Vermeulen Street
Branch code	:	632005
Account No.	:	4053643510
Account type	:	Cheque account
Beneficiary Ref.	:	SAPC Y-Number (**Note: exclude the letter Y and add zeros at the end to make 8 numbers**)

*SECTION D: DECLARATION BY THE OWNER OR RESPONSIBLE PHARMACIST

I, declare that:

(a) the information furnished herewith is true and correct
(b) I hereby include the applicable documentation/fees

Owner or Responsible Pharmacist's Signature:		**Date:**	

*SECTION E: DECLARATION BY COMMISSIONER OF OATHS

The abovementioned was SIGNED and SWORN TO before me at _____(place)

On this _____day of _____in the year_____, the deponent (applicant) having acknowledged that he/she knows and understands the contents of this declaration.

SIGNATURE OF COMMISSIONER OF OATHS _____

Stamp
(Compulsory)

(Full names, capacity, address and contact details of Commissioner of Oaths)