

## APPLICATION FOR REPRINT OF PHARMACY LICENCE AFTER CHANGE IN ADDRESS DETAILS (NO PHYSICAL MOVE)



**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](mailto:pharmapps@health.gov.za)

LU-FORM-5.3.1  
Version 3  
2024

<b>DOH LICENCE NUMBER</b> <small>(where applicable)</small>							
<b>RECORDED PHARMACY NAME</b>						<b>Y-Number</b>	
<b>RECORDED PHARMACY OWNER</b>							
<b>*SECTION A: PHARMACY PARTICULARS</b>							
<b>Pharmacy Owner</b>	Company	Close Corporation	Partnership	Sole Proprietor	Trust	State	
<b>Pharmacy Category</b>	Community	Institutional (private)	Institutional (public)	Wholesale	Manufacturing	Consultant	
<b>Name of Owner(s)</b> <small>as per CIPC registration (where applicable)</small>							
<b>CIPC Number</b> <small>(where applicable)</small>							
<b>Name of Owner(s)</b> <small>In case of sole proprietor or partnership</small>							
<b>ID number(s)</b> <small>In case of sole proprietor or partnership</small>							
<b>Physical Address</b>							
							<b>Code</b>
<b>Postal Address</b> <small>(To which licence must be sent)</small>							
							<b>Code</b>
<b>Telephone Number</b>							
<b>Fax Number</b>							
<b>Email Address</b>							
<b>*SECTION B: REASON FOR REPRINT</b>							
<b>*SECTION C: SUPPORTING DOCUMENTS AND APPLICABLE FEES</b>							
<b>I, above applicant, submit the following documents in support of this application:</b>							Mark with X
(a) Certified copy of current licence issued by the National Department of Health (where applicable)							<input type="checkbox"/>
(b) Proof of payment of licence reprint fee – R250							<input type="checkbox"/>
(c) Certified copy of current pharmacy recording certificate of Pharmacy Owner and Responsible Pharmacist with the SAPC							<input type="checkbox"/>
(d) Certified copy of licence issued by the Medicines Control Council (where applicable)							<input type="checkbox"/>
(e) Copy of company registration documents with the Companies and Intellectual Property Commission (CIPC)							<input type="checkbox"/>
<b>National Department of Health Banking Details:</b>							
Bank	:	ABSA					
Branch	:	Vermeulen Street					
Branch code	:	632005					
Account No.	:	4053643510					
Account type	:	Cheque account					
Beneficiary Ref.	:	SAPC Y-Number <b>(Note: exclude the letter Y and add zeros at the end to make 8 numbers)</b>					
<b>*SECTION D: DECLARATION BY THE OWNER OR RESPONSIBLE PHARMACIST</b>							
<b>I, declare that:</b>							
(a) the information furnished herewith is true and correct							
(b) I hereby include the applicable documentation/fees							
<b>Owner or Responsible Pharmacist's Signature:</b>				<b>Date:</b>			
<b>*SECTION E: DECLARATION BY COMMISSIONER OF OATHS</b>							<b>Stamp</b> (Compulsory)
The abovementioned was SIGNED and SWORN TO before me at _____(place)							<small>(Full names, capacity, address and contact details of Commissioner of Oaths)</small>
On this _____ day of _____ in the year _____, the deponent (applicant) having acknowledged that he/she knows and understands the contents of this declaration.							
<b>SIGNATURE OF COMMISSIONER OF OATHS</b> _____							