



health

Department: Health REPUBLIC OF SOUTH AFRICA

APPLICATION FOR REPRINT OF A YELLOW FEVER LICENCE (LOST/DAMAGED)

Please return to: National Department of Health: Licensing Unit Dr AB Xuma Building, 1112 Voortrekker Road, Pretoria Townlands 351-JR, Pretoria, 0187 EMAIL TO: yellowfeverlicences@health.gov.za Subject Line to email: Reprint, Initials, Surname, MP-Number Tel: (012)395 8314/8315

LU-FORM-6.4.1 Version 1 2024

YELLOW FEVER LICENCE NUMBER
COUNCIL REGISTRATION NUMBER (HPCSA/SANC)

*SECTION A: PRACTICE / BUSINESS PARTICULARS

Practice/Business Name
Full name(s) of dispensing licence holder
ID Number
Date licence issued
Premises Address
Postal Address
Telephone Number
Email Address (important)

*SECTION B: REASON FOR REPRINT

Empty box for reason for reprint

*SECTION C: SUPPORTING DOCUMENTS AND APPLICABLE FEES

I, above applicant, submit the following documents in support of this application:
(a) Proof of payment of reprint fee of R250
(b) Proof of current statutory council registration
(c) Copy of yellow fever licence last issued by DOH (if available)

National Department of Health Banking Details:
Bank : ABSA
Branch : Vermeulen Street
Branch code : 632005
Account No. : 4053643510
Account type : Cheque account
Beneficiary Ref. : Statutory Council Registration (Note: No alphabets 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
(c) I am in good standing with my professional council

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)