



Health Professions Council of Namibia
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Pharmacy Board of Namibia

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

Client #: _____

APPLICATION FOR REGISTRATION OF A PHARMACEUTICAL PRACTICE

Name of Business _____
 Trading as (if applicable) _____
 Alternative Trading Title: _____

Ownership of Practice:

Sole Owner
 Private Company
 Close Corporation
 Partnership

The Pharmaceutical Practice will do business as:

Pharmacy

Hospital Pharmacy

Postal Address

Telephone Office _____
 Cell _____

Fax _____
 e-mail _____

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

Envisaged opening date of pharmacy: _____

The following documents (certified by a Commissioner of Oaths must accompany the application:

1. Proof of citizenship, Permanent resident of Namibia , birth certificate , passport , identity document , Certificate of Citizenship issued by Ministry of Home Affairs & Immigration
2. Floor plan of the pharmacy drawn to scale.
3. Floor plan of the building/complex indicating the pharmacy (drawn to scale).
4. Copy of the signed lease agreement or sale agreement for the premises.
5. Copy of partnership agreement.
6. Copy of the Memorandum of Association or Founding Statement.
7. Details of any proprietary interest members hold in any other pharmaceutical practice.

Name of Business	Name of Managing Director/ Member of Business	Name of Responsible Pharmacist

8. The names and addresses of every other person who holds a proprietary interest in that other pharmaceutical practice.
9. A copy of the current registration certificate issued in relation to the private hospital under the Hospitals and Health Facilities Act, 1994 (Act No. 36 of 1994).
10. A statement setting out the following information about each person who holds a proprietary interest in the hospital pharmacy that is to be carried on in the private hospital;
 - (i) The name and address of each person;
 - (ii) The nature and extent of the interest held by each person;
 - (ii) A telephone number and email address of each person;
 - (iv) Details of any proprietary interest each person holds in any other pharmacy practice, including the nature and extent of the person's interest in such other pharmacy practice;
 - (v) The name and address of such other pharmacy practice,
 - (viii) The names and addresses of every other person who holds a proprietary interest in that other pharmacy practice.
11. A copy of the agreement between persons who hold a proprietary interest in the pharmacy practice that makes provision for any rights the persons possess by virtue of having the proprietary interests;
12. N\$ 3,930.00 Application fee for a Pharmacy
13. N\$ 7,200.00 Application fee for a Hospital Pharmacy

ELIGIBILITY FOR REGISTRATION OF A PHARMACY PRACTICE

Sole owner Name: _____ Client #: _____
 HPCNA Registration **Date:** _____ Duration in practise: _____

Managing Director _____ Client #: _____
 HPCNA Registration **Date:** _____ Duration in practise: _____
 Interest in other Proprietary: _____

Managing Member _____ Client #: _____
 HPCNA Registration **Date:** _____ Duration in practise: _____
 Interest in other Proprietary: _____

Member _____ Client #: _____
 HPCNA Registration **Date:** _____ Duration in practise: _____

APPOINTMENT OF RESPONSIBLE PHARMACIST

Responsible Pharmacist Name: _____ Client #: _____
 HPCNA Registration Date: _____ Duration in Practice: _____
 Date of appointment as the Responsible Pharmacist: _____
 Date on which active duty as the Responsible Pharmacist will commence: _____

(MARK WITH X) APPLICANT HPCNA

Letter of appointment of the Responsible Pharmacist	<input type="checkbox"/>	<input type="checkbox"/>
Letter of acceptance of that appointment by the Responsible Pharmacist	<input type="checkbox"/>	<input type="checkbox"/>
Letter of resignation from the previous pharmaceutical practice.		<input type="checkbox"/>
Certified copy of the work visa. (if Responsible Pharmacist is a non-Namibian)		<input type="checkbox"/>
Affidavit as responsible pharmacist in terms of the Pharmacy Act, 2004 (ACT NO 9 of 2004)		<input type="checkbox"/>

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"/>
The total dispensing area is _____ m ² .		<input type="checkbox"/>
The working surface with impervious covering with free working space is _____ m ² .		<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"/>
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 | <input type="checkbox"/> |
| (b) Separate refrigerator for veterinary medicines | <input type="checkbox"/> |
| (c) Separate refrigerator for the staff | <input type="checkbox"/> |
| (d) Standby generator or other emergency power | <input type="checkbox"/> |
| (e) Thermometers and temperature recording sheet available | <input type="checkbox"/> |
| (f) Lockable safe or cupboard for the storage of Schedule 4 substances; | <input type="checkbox"/> |
| (g) A dispensing balance or digital scale that is calibrated annually; | <input type="checkbox"/> |
| (h) Standard Operating Procedures (SOP's) as stipulated in Regulation No 101 of 25 July 2014 to be available on inspection. | <input type="checkbox"/> |
| (i) The following dispensing measures: | |
| (i) one x 200 ml measure; | <input type="checkbox"/> |
| (ii) one X 100 ml measure; | <input type="checkbox"/> |

- (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

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

AFFIDAVIT IN TERMS OF THE PHARMACY ACT, 2004 (ACT NO. 9 OF 2004)

Government Gazette No. 5515 of 25 July 2014, Government Notice No 101, Section 7

RESPONSIBLE PHARMACIST WHO WILL MANAGE THE PRACTICE

I, the undersigned, Prof; Dr; Mr; Mrs/Ms. _____, with ID No./
Passport No: _____, HPCNA Client No. _____ and HPCNA
Registration No. _____, is registered with the Council for _____ years and do hereby declare
that I have accepted the position as Responsible Pharmacist for _____.
Appointment date: _____.

I further declare that I am residing in Namibia and if I am currently employed will resign from my current
post to take up the appointment of the Responsible Pharmacist that will commence on _____.

Name & Signature
(Responsible Pharmacist)

Solemnly sworn / affirmed before me at _____ this
_____ day of _____ 20_____.

The Responsible Pharmacist has acknowledged that: he/she knows and understand the contents of this
affidavit; he/she has no objection taking the prescribed oath; and he/she considers the oath to be binding on
his/her conscience.

Official stamp

Name & Signature
Commissioner of Oaths

Fees payable

- Application fee for new practice 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