



**Health Professions Council of Namibia**  
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**Pharmacy Board of Namibia**

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

**APPLICATION FOR RELOCATION OF A PHARMACEUTICAL PRACTICE**

Name of Business \_\_\_\_\_

Trading as (if applicable) \_\_\_\_\_

Client #: \_\_\_\_\_

Ownership of Practice:

Sole Owner       Private Company       Close Corporation       Partnership

The Pharmaceutical Practice is doing business as:

*Pharmacy*       *Wholesale Pharmacist*       *Hospital Pharmacy*

Postal Address

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Telephone	Office		Fax	
	Cell		e-mail	

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

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

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**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. Floor plan of the pharmacy drawn to scale by an architect showing the actual layout and exact measurements with the areas as stipulated in the Government Gazette 5515, Government Notice No 101 of 24 July 2014.
3. Floor plan of the building/complex indicating the pharmacy (drawn to scale by an architect).
4. Copy of lease agreement or sale agreement for the premises.
5. Application fee for Relocation of a Pharmacy: N\$ 3,930.00
6. Application fee for Relocation of a Hospital Pharmacy: N\$ 7,250.00
7. Application fee for Relocation of a Wholesale Pharmacist: N\$ 9,030.00

**PARTICULARS OF RESPONSIBLE PHARMACIST**

Responsible Pharmacist Name: \_\_\_\_\_ Client #: \_\_\_\_\_  
 HPCNA Registration Date: \_\_\_\_\_ Duration in practise: \_\_\_\_\_

Date when the Responsible Pharmacist was appointment: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Responsible Pharmacist

\_\_\_\_\_  
 Date

**REQUIREMENTS: PREMISES OF A PHARMACY PRACTICE**

(MARK WITH X) APPLICANT HPCNA

- |  |                          |                          |
|--|--------------------------|--------------------------|
| The total floor area of the pharmacy premises is _____ m <sup>2</sup> .                        |                          | <input type="checkbox"/> |
| The total dispensing area is _____ m <sup>2</sup> .  |                          | <input type="checkbox"/> |
| The working surface with impervious covering with free working space is _____ m <sup>2</sup> . |                          | <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 <sup>2</sup>             |                          | <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.

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**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\$ \_\_\_\_\_

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

