South African Pharmacy Council
591 Belvedere Street, Arcadia, Pretoria, 0083; Private Bag X40040, Arcadia, 0007;
Tel: 0861 7272 00; Fax: 27 (12) 321 1479; E-mail: customercare@sapc.za.org; Website: www.sapc.za.org

Form is valid for **2021** only

APPLICATION FOR ISSUING OF A DUPLICATE CERTIFICATE FOR A PHARMACY, OWNER OR RESPONSIBLE PHARMACIST IN TERMS OF THE PHARMACY ACT 53 OF 1974

Please use black ink and complete in BLOCK CAPITALS.
Return to: The Registrar, South African Pharmacy Council, to the postal address above

SECTION A: APPLICANT'S PERSONAL PARTICULARS

Facility's Y no: Y | RP's P No. P

Surname/last name

Title | Initials (first names)

First names in full

Identity number or Permit number

Date of birth (/ /) | **Gender and race** | Male | Female | **Race** | Asian | Black | Coloured | White

Cell phone number
Work telephone number

Fax telephone number

E-mail address

Name of the Pharmacy

Courier address

Street code

SECTION B: APPLICABLE FEES (TICK IN THE APPROPRIATE BLOCK(S)

Recording of a facility **R2,306.00** (VAT incl)	Recording of a facility (Pre - may 2003) **R2, 306.00** (VAT incl)	Owner **R2, 306.00** (VAT incl)	Approval of a Pharmacy Premises for training purposes **R2, 306.00** (VAT incl)	Grading of a Pharmacy Certificate **R2, 306.00** (VAT incl)	Other **R2, 306.00** (VAT incl)

SECTION D: DECLARATION BY APPLICANT

I, the above applicant, declare that:

a) I have not been found guilty of any offence under the Pharmacy Act, 1974, as amended; and

b) The information furnished herewith is true and correct.

Applicant's Signature: _____ **Application Date:** D D / M M / Y Y Y Y

SECTION F: DECLARATION BY COMMISSIONER OF OATHS

The abovementioned was SIGNED and SWORN TO before me at

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)

SAPC Electronic Payment Details (If not yet captured on Council's financial system)

Name of Beneficiary	**South African Pharmacy Council**
Name of Bank	**Standard Bank of South Africa**
Account type	**Cheque account**
Branch Code	**0 1 0 1 4 5**
Beneficiary Account number	**0 1 1 8 8 5 8 6 6**
Beneficiary Reference	***Your account number ** with SAPC and surname & initials.***

PLEASE NOTE:

1. This application is **valid for 60 days from date of receipt by the Office of the Registrar**. Should you **fail to submit all the required supporting documentation** and fees/proof of payment of fees within 60 days of this application the application will be invalid and all fees (excluding annual fee) that may have been paid herewith shall be forfeited.
2. **Cash, postal orders and cheques will not be accepted with any application form.**
3. **South African Pharmacy Council has a policy of zero tolerance to fraud and corruption. All fraud and corruption cases detected or reported will be investigated and perpetrators will be prosecuted accordingly.**

Signature_____ Date_____