



# South African Pharmacy Council

591 Belvedere Street, Arcadia, Pretoria, 0083; Private Bag X40040, Arcadia, 0007;  
Tel: 0861 7272 00; E-mail: [customer@sapc.za.org](mailto:customer@sapc.za.org); Website: [www.sapc.za.org](http://www.sapc.za.org)

Form is valid for  
**2026** only

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## APPLICATION FOR THE CLOSURE OF A PHARMACY 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		Office Use Only						
<b>PARTICULARS OF THE OWNER AND THE PHARMACY TO BE ERASED</b>								
Pharmacy owner	<table border="1"> <tr> <td>Company</td> <td>Close Corporation</td> <td>Partnership</td> <td>Sole Proprietor</td> <td>Trust</td> <td>State</td> </tr> </table>	Company	Close Corporation	Partnership	Sole Proprietor	Trust	State	
Company	Close Corporation	Partnership	Sole Proprietor	Trust	State			
Category of pharmacy	<table border="1"> <tr> <td>Community C1</td> <td>Institutional (private) C13</td> <td>Wholesale C8</td> <td>Manufacturing C6</td> <td>Consultant C14</td> <td>Institutional Public C2</td> </tr> </table>	Community C1	Institutional (private) C13	Wholesale C8	Manufacturing C6	Consultant C14	Institutional Public C2	
Community C1	Institutional (private) C13	Wholesale C8	Manufacturing C6	Consultant C14	Institutional Public C2			
Full name(s) of owner (company, close corporation, person etc.)	<div></div> <div></div>							
Pharmacy account number	Y <div></div>							
Trading title of the pharmacy as recorded with Council?	<div></div>							
Pharmacy physical address (as recorded with Council)	<div></div> <div></div> <div></div> <div></div> <div>Street code</div> <div></div>							
Pharmacy telephone number	( <div></div> ) <div></div> - <div></div>							
Pharmacy fax number	( <div></div> ) <div></div> - <div></div>							
Pharmacy e-mail address	<div></div>							
when was or is the pharmacy intending to cease trading	DD / MM / YYYY							
<b>PARTICULARS OF THE RESPONSIBLE PHARMACIST (RP)</b>								
RP Reg Number	<div></div>	RP Account number (if available) P <div></div>						
Surname/Last Name	<div></div>							
Title	<div></div>	Initials (First Names) <div></div>						
First Names In Full	<div></div>							
Cell number	<div></div>							
E-mail address	<div></div>							
Courier address	<div></div>							
	<div></div>							
	<div></div>	Code <div></div>						
Identity Number or	<div></div>							

Applicant's signature \_\_\_\_\_

Date \_\_\_\_\_



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Passport number		
<b>REASONS FOR CLOSURE</b>  Choose one of the reasons below or specify the reason for closure a) Financial reasons b) Liquidation c) Pricing regulations d) Property sold e) No responsible pharmacist f) Owners request g) Others, please specify _____		
		Mark with a ✓ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>SUPPORTING DOCUMENTATION</b>		
I, the above applicant, submit the following in support of this application: a) a copy of the licence to own a pharmacy issued by the department of Health in terms of the Pharmacy Act 53 of 1974 as amended b) a list of all tutors, Interns and learners (each with his or her role type) that are currently practising in this facility; c) a legal document containing a list of shareholders, members, trustees etc, or a document signed by shareholders appointing you as a liaising personnel (except In case of a sole proprietorship) .		
		Mark with a ✓ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>DECLARATION BY THE OWNER OR RP</b>		
I, declare that: - a) I herewith include the applicable documentation; b) I am the RP or sole owner of the pharmacy or have been empowered by the company, members or trustees etc, to request the Council to close the above mentioned pharmacy. c) the information furnished herewith is true and correct.		
RP or Owners Signature: <input type="text"/>		
Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

Applicant's signature \_\_\_\_\_

Date \_\_\_\_\_