

## APPLICATION FOR ACCESS RIGHTS TO PHARMACY OWNERS

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

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### SECTION A: PARTICULARS OF THE OWNER

Pharmacy Ownership Type	Company	Close Corporation	Partnership	Sole Proprietor	Trust	State
Category of Pharmacy	Community C1	Institutional (private) C13	Wholesale C8	Manufacturing C6	Consultant C14	Institutional (Public) C2
Pharmacy Name / Trading Title						
Pharmacy Y-number						
Juristic Name of Owner (state entity, company, close corporation, pers, etc.)						
CIPC Number (if applicable)						
ID Number (sole proprietor / Partnership)						
Full Name of Head of Pharmaceutical Services for the Pharmacy Group / Province / Metro / SANDF/ SAPS and Correctional Services						
Owner's telephone number	( )	-				
Owner's cell phone number	( )	-				
Owner's e-mail address						

### SECTION B: PARTICULARS OF THE DELEGATED PERSON (complete for each delegated person)

Surname/Last Name			
Title		Initials (First Names)	
First Names In Full			
Identity Number or Passport number			
Business Physical Address			
		Street code	
Contact Telephone Number	( )	-	
Cell Number	( )	-	
E-mail Address			

### SECTION C: ACCESS RIGHTS

Please indicate the access rights required for the delegated person	Mark with a ✓
a) <b>CSP Progression – Progress Community Service Pharmacists</b>	
b) All pharmacies (IF NOT, refer to (c) below)	
c) Selected pharmacies (provide a list of pharmacies with Y numbers)	
d) Update postal and courier addresses	
e) Employment details – all registered persons	
f) Finance – make payments, download invoices and receipts	
g) Inspections – view inspection information	
h) Responsible pharmacist – view pharmacies' RPs and their contact details	
i) Premises approval – view duration of premises approvals	
j) All role types – View all staff employed per facility	

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

Date \_\_\_\_\_

## APPLICATION FOR ACCESS RIGHTS TO GROUP PHARMACY

### SECTION D: SUPPORTING DOCUMENTATION

I, the above applicant, submit the following in support of this application:

Mark  
with a ✓

a) A certified copy ID for the delegated person

☐

b) Letter of delegation from the national or Provincial Department of Health (**For Public Sector**)

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c) Company Resolution (**For juristic persons**)

☐

### SECTION E: DECLARATION BY THE OWNER / REPRESENTATIVE

I, declare that-

a) I herewith include the applicable documentation;

b) the information furnished herewith is true and correct.

Owners Signature:

Date:

D	D	/	M	M	/	Y	Y	Y	Y
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Applicant's signature\_\_\_\_\_

Date\_\_\_\_\_