



South African Pharmacy Council

Form is valid for
2026 only

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Tel: 0861 7272 00; E-mail: customer@sapc.za.org; Website: www.sapc.za.org

COMPLETION OF PHARMACEUTICAL COMMUNITY SERVICE

DECLARATION BY PHARMACIST IN CHARGE

I, the undersigned

Title	<input type="text"/>	Initials (first names)	<input type="text"/>	Pharmacist account no (if available)	<input type="text" value="P"/>
Surname/last name	<input type="text"/>				
First names in full	<input type="text"/>				
Pharmacy Reg no	<input type="text" value="Y"/>				
Pharmacy Name	<input type="text"/>				
Province/Authority	<input type="text"/>				
Cell number	<input type="text"/>				
Work Tel number	<input type="text"/>				
Fax number	<input type="text"/>				
E-mail address	<input type="text"/>				

AS THE PHARMACIST IN CHARGE HEREBY DECLARE THAT –

Title	<input type="text"/>	Initials (first names)	<input type="text"/>	Pharmacist account no (if available)	<input type="text" value="P"/>
Surname/last name	<input type="text"/>				
First names in full	<input type="text"/>				
ID number	<input type="text"/>				
Cell number	<input type="text"/>				

WAS REGISTERED AS A PHARMACIST FOR THE PURPOSE OF PERFORMING PHARMACEUTICAL COMMUNITY SERVICES IN TERMS OF THE PHARMACY ACT 1974 AS AMENDED, AND HAS WORKED AT THIS INSTITUTION TO FULFILL HIS/HER STATUTORY 12 MONTHS PHARMACEUTICAL COMMUNITY SERVICE TO THE SATISFACTION OF THE DEPARTMENT/PROVINCE/AUTHORITY

Commencement Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
Completion Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>

(The 12 months is calculated from the official registration date with SAPC)

STAMP

Signature:
Pharmacist in Charge

Signature: Head of
Pharmaceutical
Services

Full names: Head of
Pharmaceutical Services

Contact number

Date: