



health

Department: Health
REPUBLIC OF SOUTH AFRICA



South African Pharmacy Council

NOMINATION FORM

NOMINATION FORM FOR CANDIDATES TO BE CONSIDERED FOR APPOINTMENT TO SERVE AS A MEMBER OF THE SOUTH AFRICAN PHARMACY COUNCIL

Requirements of a valid nomination: Each nomination must be duly completed and signed by the person making the nomination and the nominee. Failure to sign the nomination form may lead to disqualification of the nomination. The completed form together with a comprehensive Curriculum Vitae (CV) of the nominee should be attached, including certified copies of academic qualifications and the nominee’s identity document as well any other relevant supporting documents.

Nominations should be addressed to the Director-General, Department of Health, and marked for the attention of the Director: Public Entities Governance and submitted via email to nominations@health.gov.za

Closing Date: 01 September 2023 at 16h00.

NOMINEE DETAILS												
Title:		First name:						Surname:				
Gender:				ID Number:								
Male		Female										
Race:												
African		White		Coloured		Indian		Other				
Nationality						Province						
Have you been convicted or found guilty of a criminal offence (including an admission of guilt)												
Yes		No				If Yes (provide details)						
Do you have any pending criminal case against you?										Yes		No
If yes, (provide details)												
CONTACT DETAILS												
Postal/Residential address:												
Cell No:						Tel No:						

E-mail address:

ACADEMIC QUALIFICATIONS (attach certified copies):

Qualification	Institution

WORK EXPERIENCE (attach a detailed CV):

Company/Department	Position Held	Appointment Date

BOARD/COUNCIL//TRIBUNAL COMMITTEE EXPERIENCE:

Entity/Institution:	Board/Council/Tribunal Role	Appointment Date	Termination Date

MOTIVATION FOR THE NOMINATION:

BRIEF DETAIL OF THE NOMINEE'S EXPERIENCE, SKILLS AND KNOWLEDGE:

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CONFLICT OF INTERESTS

I hereby confirm that neither myself, my spouse or immediate family member are employed, have direct or indirect business interest with the National Health Laboratories Service, and its subsidiaries.

Yes	No	If Yes (provide details below)
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Details of interests:

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Disqualification conditions: No person shall be appointed as a member of the Council if he or she-

- (a) his estate is sequestrated;
- (b) he is or becomes disqualified under this Act from practising his profession;
- (c) he becomes a patient as defined in section 1 of the Mental Health Act, 1973 (Act 18 of 1973);
- (d) he is convicted of an offence in respect whereof he is sentenced to imprisonment without the option of a fine; and
- (e) he ceases to be a South African citizen;

NOMINEE ACCEPTANCE, DECLARATION AND CONSENT TO PROCESS (USE) PERSONAL INFORMATION (TO BE COMPLETED BY THE PERSON ACCEPTING THE NOMINATION):

Category of nomination (TICK ONLY ONE):

- on account of my extensive knowledge in law
- on account of my extensive knowledge in consumer/patient rights
- on account of my track record in serving the rights of disadvantaged communities

I, the undersigned,

Signature: _____

(Surname, full name(s) and ID number)

SIGNED AT _____ (place) ON _____ (date)

Hereby confirm that I have read and understood the disqualification conditions above and that I am fully qualified to be appointed; I have also read and understood the remuneration applicable and therefore accept the nomination to serve on the **South African Pharmacy Council**.

I declare that all information provided (including any attachments) is complete and correct to the best of my knowledge. I understand that any false information provided will result in my nomination being disqualified. I give my consent to the Department to process (use) the personal information I have submitted in accordance with the Protection of Personal Information Act, 2013 (Act No. 4 of 2013), as amended.

DETAILS OF THE INSTITUTION AND/OR INDIVIDUAL MAKING THE NOMINATION:	
Name	
Organisation	
Postal/Residential Address	
Contact numbers	
E-mail	
Relationship to nominee	
Signature	
Date	