DEPARTMENT OF HEALTH

DIRECTORATE: AFFORDABLE MEDICINES

PRIVATE BAG X828, PRETORIA 0001
EMAIL: dispensepps@health.gov.za
TELEPHONE : 012-395-8314/8315 **FACSIMILE : 0866 210 829**

APPLICATION FOR A LICENCE TO COMPOUND OR DISPENSE MEDICINES IN TERMS OF SECTION 22C (1) (a) OF THE MEDICINES AND RELATED SUBSTANCES ACT, 1965 (ACT 101 OF 1965), AS AMENDED

SECTION A: GENERAL INFORMATION

1. Title*	
2. Surname of Applicant*	
3. Full names of Applicant*	
4. Identity Number of Applicant*	

SECTION B: RESIDENTIAL ADDRESS

1. Street Address of Applicant*	
Code	
2. Postal Address of Applicant*	
Postal Code*	

SECTION C: BUSINESS ADDRESS (where dispensing will take place)

1. Street Address of Premises*	
Code	Province*
2. Postal Address of Premises*	
Postal Code*	
Home Telephone Number	- -
Business Phone Number*	- -
Fax Number of Applicant	- -
Cell Number of Applicant*	- -
E-mail address	

SECTION D: QUALIFICATIONS

Profession (specify)*	
Qualification*	
Name of Statutory Council*	
Statutory Council Registration Number*	
Qualification	
Name of Statutory Council	
Statutory Council Registration Number	
Qualification	
Name of Statutory Council	
Statutory Council Registration Number	

SECTION E: DISPENSING COURSE

Name of SAPC Accredited Provider*	
Name of Course Completed*	
Date of Completion*	

***SECTION F: PARTICULARS OF THE PREMISES**		
I, _____ , as the applicant, declare that:		
1. The size of the premises is		m^2
2. Key, key card or other device or the combination of any device, which allows access to the dispensary is kept on the person of the authorized prescriber .	Yes	No
3. Only the authorized prescriber has keys to the pharmacy area where schedule 1 – 6 items are kept.	Yes	No
4. There is sufficient security to prevent unauthorised access to medicines.	Yes	No
5. The pharmacy will be suitably located in the consulting rooms.	Yes	No
6. The dispensary is suitably located in the pharmacy.	Yes	No
7. The pharmacy is accessible to persons with disabilities.	Yes	No
8.There is/ will be a separate facility for washing hands	Yes	No
9.There is/ will be a separate facility for cleaning of equipment	Yes	No
10.The premises will be kept clean, orderly and tidy.	Yes	No
11.The floor surface will be of impermeable material.	Yes	No
12.All working surfaces will be finished with a smooth impermeable and washable material	Yes	No
13. All countertops and shelves will be finished with a smooth, impermeable and washable material which is easy to keep clean	Yes	No
14. Walls are finished with a smooth, impermeable and washable material, which is easy to keep clean	Yes	No
15. There will be sufficient and adequate lighting.	Yes	No
16. There is an air conditioner in the pharmacy which is in good working condition.	Yes	No
17. The temperature in the dispensary will be below 25 ^{0}C.	Yes	No
18. There is at least one fire extinguisher or fire hose in the pharmacy.	Yes	No
19. There will be a suitable waiting area, in accordance with Good Pharmacy Practice (GPP) guidelines	Yes	No
20. There is a suitable private area for the provision of information and advice, in accordance with GPP standards.	Yes	No
21. There is a suitable area for the screening and performing of tests.	Yes	No
22. The professional image of the dispensing area is not affected by the display of commercial material not directly linked with health.	Yes	No
23. The pharmacy is designated as a non-smoking area.	Yes	No
24. The receiving area for deliveries will be clearly defined and separated from the rest of the pharmacy	Yes	No
25. A fridge for heat sensitive pharmaceuticals and vaccines will be available.	Yes	No
26. A nurse prescriber - only patient ready packs or original packings	Yes	No
27. No bulk stock is kept on premises	Yes	No

SECTION G: SUPPORTING DOCUMENTATION*

1. Certified copy of Certificate of successful completion of a course in dispensing, or compounding and dispensing.	☐
2. Certified copy of Proof of current registration with the Statutory Council	☐
3. Certified copy of Identity Document	☐
4. Proof of payment of application and/or annual fees.	☐

SECTION H: FOR NURSES ONLY (see page 4)*

1. Section 56(6) authorisation signed by authorising doctor*	☐
2. Proof of Areas of Specialisation and Protocol Competencies (certified)*	☐
3. Confirmation of employment on company letter head and signed by authorised manager*	☐

SECTION I: DECLARATION BY THE APPLICANT*

1. I hereby give consent for an inspection of the premises in terms of the applicable legislation.
2. The information furnished herewith is true and correct.

APPLICANT'S SIGNATURE: ……..

DATE: ☐☐ - ☐☐ - ☐☐☐☐
D D M M Y Y Y Y

SECTION J: DECLARATION BY COMMISSIONER OF OATHS*

SIGNED and SWORN TO before me on this ---------- day of ---------- in the year ----------
The deponent (applicant) having acknowledged that he/she understands the contents of this declaration.

SIGNATURE OF COMMISSIONER OF OATHS

DATE: ----------

STAMP

This form may be completed and submitted to the Director-General ONLY IF the applicant has completed the supplementary course on dispensing and/or compounding.

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SECTION H: AUTHORITY UNDER SECTION 56(6) OF THE NURSING ACT, 2005 (ACT 33 OF 2005)

1. Name of Nurse	
2. Name of Clinic/Facility	

You are hereby authorised to diagnose prescribe and dispense medicines for the conditions listed in the standing orders of the clinic according to the treatment protocols listed in the standing orders of the clinic according to the treatment protocols listed below subject to the limitations imposed by the Regulations to Section 38A of the Nursing Act.

You are to maintain legible, comprehensive clinical notes in the patient file and to complete the drug register required under the licence issued in terms of section 22C (1) (a) of the Medicines and Related Substances Act (Act 101 of 1965) as amended.

Name of Medical Practitioner in charge: …….....

Signed at …….... on …… day of …… 20……..

Signature: ……. Qualification(s): …….....

HPCSA No: ……

Address: ……

……

……

Tel: (……) ……....

Note: Attach confirmation of employment on company letter head, signed by the authorised manager.

Area of Specialisation (Attach proof of completion)	Mark with X	Proof Attached (state YES or NO)
Primary Health Care		
Occupational Health		
Other(specify)		
Protocol Competencies	**Mark with X**	**Proof Attached (state YES or NO)**
STI		
EPI		
TB		
Diabetes		
Hypertension		
Travel Medicines		
Other(specify)		
Other(specify)		