



# The South African Pharmacy Council

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

Form is valid for  
**2025** only

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## APPLICATION FOR RESTORATION OF A NAME TO THE REGISTER DUE TO VOLUNTARY REMOVAL 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, to the postal address above

### SECTION A: APPLICANT'S PERSONAL PARTICULARS

Council registration number	<input type="text"/>	Council account number	<b>P</b>	<input type="text"/>
Surname/last name	<input type="text"/>			
Title	<input type="text"/>	Initials (first names)	<input type="text"/>	
First names in full	<input type="text"/>			
Identity number or Permit number	<input type="text"/>			
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Gender and race	Male	Female
Postal address	<input type="text"/>		Race	Asian   Black   Coloured   White
Physical address	<input type="text"/>		Postal code	<input type="text"/>
Courier address	<input type="text"/>		Street code	<input type="text"/>
Cell phone number	<input type="text"/>			
Work telephone number	<input type="text"/>			
Fax telephone number	<input type="text"/>			
E-mail address	<input type="text"/>			
<b>Category of Registration:</b> (Please tick applicable block)	<input type="checkbox"/> Student	<input type="checkbox"/> Intern	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Assistant – Basic & Post-Basic

### SECTION B: TRAINING PARTICULARS OF APPROVED PHARMACY AND TUTOR (TO BE COMPLETED BY PHARMACIST'S ASSISTANTS LEARNERS (BASICS AND POST BASICS) ONLY

Name of pharmacy/institution approved for training	<input type="text"/>			
Sector of Pharmacy	<input type="checkbox"/> Private Sector	<input type="checkbox"/> Public Sector	Pharmacy registration no	<b>Y</b>
Branch of pharmacy	<input type="checkbox"/> Institutional (hospital)	<input type="checkbox"/> Community	<input type="checkbox"/> Manufacturing	<input type="checkbox"/> Wholesale
Name of pharmacy/institution approved for training	<input type="text"/>			
Tutor registration no	<input type="text"/>	Tutor account no: (if available)	<b>P</b>	<input type="text"/>
Tutor surname/last name	<input type="text"/>			
Tutor Title	<input type="text"/>	Tutor Initials (first names)	<input type="text"/>	
<b>Tutor Signature</b>	<input type="text"/>	<b>Application Date:</b>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
Provider with whom registered for a certificate of qualification in pharmacy e.g. HSA, S BUYS etc.	<input type="text"/>			
Provider – Pharmacy Council registration no	<input type="text"/>			

### SECTION C: APPLICABLE FEES

<b>Student</b> R 1 397.00 - (Section 23(1)(c) of Act 53 of 1974)	<b>Intern</b> R 1 397.00 - (Section 23(1)(c) of Act 53 of 1974)	<b>Pharmacist</b> R 2 752.00 - (Section 23(1)(c) of Act 53 of 1974)	<b>Assistant – Basic &amp; Post-Basic</b> R 1 397.00 - (Section 23(1)(c) of Act 53 of 1974)
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### SECTION D: SUPPORTING DOCUMENTATION AND APPLICABLE FEES

I, the above applicant, submit the following in support of my application: Mark with a ✓

(a) Restoration fee as described in section C	<input type="checkbox"/>
(b) Copy of a degree or certificate for completion of a qualification	<input type="checkbox"/>

## APPLICATION FOR RESTORATION DUE TO VOLUNTARY REMOVAL OF A NAME TO THE REGISTERS IN TERMS OF THE PHARMACY ACT 53 OF 1974 ..... (Continued)

### SECTION E: DECLARATION BY APPLICANT

Signature \_\_\_\_\_

Date \_\_\_\_\_



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I, the above applicant, declare that:

- a) I herewith include all the applicable documentation/fees mentioned in Section D above;
- b) I comply with the requirements for registration as a pharmacist's assistant (learner basic) or pharmacist's assistant (learner post-basic);
- c) I have not been found guilty of any offence under the Pharmacy Act, 1974, as amended; and
- d) The information furnished herewith is true and correct.

Applicant's Signature: \_\_\_\_\_ Application Date: 

DD	MM	YY	YY
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## SECTION F: DECLARATION BY COMMISSIONER OF OATHS

The abovementioned was SIGNED and SWORN TO before me at \_\_\_\_\_  
(place)  
on this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_, the deponent (applicant) having  
acknowledged that he/she knows and understands the contents of this declaration.

**STAMP**  
(Compulsory)

SIGNATURE OF COMMISSIONER OF OATHS

(Full names, capacity, address and  
contact details of  
Commissioner of Oaths)

### SAPC Electronic Payment Details (If not yet captured on Council's financial system)

Name of Beneficiary	South African Pharmacy Council												
Name of Bank	Standard Bank of South Africa												
Account type	Cheque account												
Branch Code	0	1	0	1	4	5							
Beneficiary Account number	0	1	1	8	8	5	8	6	6				
Beneficiary Reference	<b>Your account number ** with SAPC and surname &amp; initials.</b>												

### PLEASE NOTE:

1. This application is valid for 60 days from date of receipt by the Office of the Registrar. Should you fail to submit all the required supporting documentation and fees/proof of payment of fees within 60 days of this application the application will be invalid and all fees (excluding annual fee) that may have been paid herewith shall be forfeited.
  2. Cash, postal orders and cheques will not be accepted with any application form.
  3. South African Pharmacy Council has a policy of zero tolerance to fraud and corruption. All fraud and corruption cases detected or reported will be investigated and perpetrators will be prosecuted accordingly.
1. For Pharmacist only:
    - a. If your application for restoration is received within 60 days after your name has been removed from the registers of Council, all sub-roles e.g. Tutor, Responsible Pharmacist and Assessors, will also be restored;
    - b. If your application for restoration is received after 60 days from the date of erasure, you will be expected to re-apply for registration and or approval for all your relevant sub-roles.

Signature \_\_\_\_\_

Date \_\_\_\_\_