



# South African Pharmacy Council

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

Form is valid for  
**2025** only

Page 1 of 2

## APPLICATION FOR THE CLOSURE OF A PHARMACY 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		Office Use Only	
<b>PARTICULARS OF THE OWNER AND THE PHARMACY TO BE ERASED</b>			
Pharmacy owner	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
Full name(s) of owner (company, close corporation, person etc.)	<input type="text"/>		
	<input type="text"/>		
Pharmacy account number	Y	<input type="text"/>	
Trading title of the pharmacy as recorded with Council?	<input type="text"/>		
Pharmacy physical address (as recorded with Council)	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		
	<input type="text"/>		Street code <input type="text"/>
Pharmacy telephone number	( <input type="text"/> )	<input type="text"/> - <input type="text"/>	
Pharmacy fax number	( <input type="text"/> )	<input type="text"/> - <input type="text"/>	
Pharmacy e-mail address	<input type="text"/>		
when was or is the pharmacy intending to cease trading	DD / MM /	YYYY	
<b>PARTICULARS OF THE RESPONSIBLE PHARMACIST (RP)</b>			
RP Reg Number	<input type="text"/>	RP Account number (if available)	P <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"/>		
Cell number	<input type="text"/>		
E-mail address	<input type="text"/>		
Courier address	<input type="text"/>		
	<input type="text"/>		Code <input type="text"/>
Identity Number or	<input type="text"/>		

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

Date \_\_\_\_\_



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Page 2 of 2

Passport number	
<p><b>REASONS FOR CLOSURE</b></p> <p>Choose one of the reasons below or specify the reason for closure</p> <p>a) Financial reasons</p> <p>b) Liquidation</p> <p>c) Pricing regulations</p> <p>d) Property sold</p> <p>e) No responsible pharmacist</p> <p>f) Owners request</p> <p>g) Others, please specify _____</p>	<p>Mark with a ✓</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<p><b>SUPPORTING DOCUMENTATION</b></p> <p>I, the above applicant, submit the following in support of this application:</p> <p>a) a copy of the licence to own a pharmacy issued by the department of Health in terms of the Pharmacy Act 53 of 1974 as amended</p> <p>b) a list of all tutors, Interns and learners (each with his or her role type) that are currently practising in this facility;</p> <p>c) a legal document containing a list of shareholders, members, trustees etc, or a document signed by shareholders appointing you as a liaising personnel (except In case of a sole proprietorship) .</p>	<p>Mark with a ✓</p> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>DECLARATION BY THE OWNER OR RP</b>	
<p>I, declare that: -</p> <p>a) I herewith include the applicable documentation;</p> <p>b) I am the RP or sole owner of the pharmacy or have been empowered by the company, members or trustees etc, to request the Council to close the above mentioned pharmacy.</p> <p>c) the information furnished herewith is true and correct.</p> <p>RP or Owners Signature: <input type="text"/></p> <p>Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>	

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

Date \_\_\_\_\_