health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Tel: 012 395 8314/8315
Fax: 086 6210 829

Civitas South Building, Cnr Thabo Sehumbe & Struben Str, Pretoria
Email: dispensepps@health.gov.za

NATIONAL DEPARTMENT OF HEALTH

AFFORDABLE MEDICINES: LICENSING UNIT

DISPENSING LICENCE AMENDMENT FORM

- RELOCATION OF DISPENSING LICENCE
- APPLICATION FOR ADDITIONAL PREMISES TO BE LICENCED

GUIDELINES

I: General Information

1. Dispensing Licence applications are made to the Director-General: Health, in terms of Section 22C(1)a of the Medicines and Related Substances Act (Act 101 of 1965), as amended.
2. All applications must be completed in full, using black ink. Fields marked with * are compulsory. **Incomplete applications will not be processed.**
3. Completed application forms and supporting documents may be emailed to dispensepps@health.gov.za.
4. Before submitting the application form, have the following documents on hand:
    a. Certified copy of Identity Document
    b. Certified copy of your registration card with Statutory Council
    c. Certified copy of existing dispensing licence
    d. Proof of payment of the non-refundable amendment application fee of R250 and annual fee.
    e. **Nurses only:**
        i. Completed and signed **Section B** of application form
        ii. Confirmation of employment on company letter head and signed by an authorised manager
5. **NOTE: Applications are processed within 90 days of receipt of all required documents.**
6. Application outcomes are posted to applicants via registered mail, to the postal address supplied on the application form. They may also be collected from the Department in person. Applicants may also send by courier (at own cost) to collect.

II: Application & Annual Fees Payable

- A non-refundable application fee of R250-00. **No Cheque payments are accepted.**
- An annual fee of R200-00 per year must be paid on application, and is payable yearly after that on or before 28 February.
- Proof of payment of both amounts must be submitted together with your application form.
- Your Statutory Council Number **(without the Prefix Letters)** must be used as the reference when making payments to the Department.

Review date: 17/03/2015

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- **Note: Where the Statutory Council Number is less than 8 (eight) numbers – please add zero's at the end to make up 8 (eight) numbers.**
- Payments to the National Department of Health are payable to the following account:

Banking details:

Bank	:	ABSA
Account Holder	:	National Department of Health
Branch	:	Vermeulen Street
Branch code	:	632005
Account No.	:	405 364 3510
Account type	:	Cheque account
Beneficiary Ref.	:	Statutory Council Registration Number ONLY

III: Delivery Address

POSTAL ADDRESS	COURIER/HAND DELIVERY
National Department of Health Affordable Medicines: Licensing Unit Civitas Building, South Tower – 4th Floor Private Bag x828 Pretoria 0001	National Department of Health Affordable Medicines: Licensing Unit Civitas Building, South Tower – 4th Floor Cnr Thabo Sehume & Struben Streets Pretoria Central 0001

IV: Enquiries

EMAIL (preferred)	:	dispensepps@health.gov.za
Telephone	:	012 395 8314/8315
Facsimile	:	086 621 0829

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SECTION A

Application for the Amendment to Dispensing Licence issued in terms of Section 22C(1)(a) of the Medicines & Related Substances Act 101 of 1965, as amended.

APPLICANT DETAILS

Name(s) and Surname		Title	
ID Number of Applicant (Supply ID copy)			
Council Registration Number (Supply proof of registration)			
Dispensing Licence Number (Supply copy of licence)			

APPLICATION CATEGORY

Category	Mark with X
Additional Premises	
Relocation of Premises	
Cancellation of Existing Licence	
Other (specify)	

CHECKLIST OF ATTACHED DOCUMENTS	Mark with X
Certified copy of Identity Document	
Certified copy of current dispensing licence	
Proof of registration with statutory body	
Section B & Proof of employment **(nurses only)**	

MAIN LICENCED PREMISES PHYSICAL ADDRESS	ADDITIONAL/RELOCATION PREMISES PHYSICAL ADDRESS
POSTAL ADDRESS	
Province:	**Province:**
Business Phone Number:	**Business Phone Number:**
Applicant Cell Number	**Business Fax Number:**
Email Address:	

REASON FOR AMENDMENT

DECLARATION BY APPLICANT

I _____**declare that all information supplied in this form is true and correct:**

Signature: _____ **Date:** _____

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SECTION B: AUTHORITY UNDER SECTION 56(6) OF THE NURSING ACT (ACT 53 OF 2005)

1. Name of Nurse	
2. ID Number	
3. SANC Number	
4. 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, and according to the treatment protocols listed below, and subject to 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	
HPCSA	
Address	
Telephone Number	

Signed at _____ on _____day of _____20___

Signature _____ Qualification(s) _____

Note:
Attach proof of employment on the official company letterhead, signed by the authorised person.

Area of Specialisation	Tick below	Proof Attached (YES or NO)	Protocol Competencies	Tick below	Proof Attached (YES or NO)
Primary Health Care			Sexually Transmitted Infections (STI)		
Occupational Health			Expanded Programme of Immunisation (EPI)		
Other (specify below)			Tuberculosis (TB		
			Diabetes		
			Hypertension		
			Travel Medicines		
			Other (specify)		
			Other (specify)		