Pharmacy Council

**APPLICATION FOR VARYING PHARMACY BUSINESS OPERATING PERMIT**

I..... wish to apply for the following change(s)
(Authorised representative)

***Please tick as appropriate***

Section A - Change of business name ☐

Section B - Change of ownership ☐

Section C - Change of location ☐

Section D - Change of Pharmacist ☐

Signature of Applicant..... Designation.....

Date.....

**SECTION A**

## CHANGE OF BUSINESS NAME

I……hereby
***(FULL NAME OF APPLICANT)***

apply to change the name of my pharmacy from

……Retail ☐ Wholesale☐ Wholesale/Retail ☐
***(Current name of pharmacy)***

to …….. Retail ☐ Wholesale☐ Wholesale/Retail ☐
***(Proposed new name of pharmacy)***

### *REASONS FOR CHANGE OF NAME:*

……

……

……

**TO BE COMPLETED BY SUPERINTENDENT PHARMACIST**

**I wish to certify that all the above information is correct to the best of my knowledge and hereby accept to be the Superintendent Pharmacist for the business.**

…… ……
***(NAME OF SUPERINTENDENT PHARMACIST)*** ***(REGISTRATION NUMBER)***

…… ……
**(Signature)** **(Date Signed)**

**SECTION B**

## CHANGE OF OWNERSHIP

**HAS THERE BEEN ANY CHANGE IN SHAREHOLDING/DIRECTORSHIP? Yes ☐ No ☐**

***If yes complete the following tables***

| ORIGINAL SHAREHOLDERS | ORIGINAL DIRECTORS |
|---|---|
| | |
| | |
| | |
| | |

| NEW SHAREHOLDERS | NEW DIRECTORS |
|---|---|
| | |
| | |
| | |
| | |

**TO BE COMPLETED BY SUPERINTENDENT PHARMACIST**

**I wish to certify that all the above information is correct to the best of my knowledge and hereby accept to be the Superintendent Pharmacist for the business.**

| | |
|---|---|
| ..... | ..... |
| ***(NAME OF SUPERINTENDENT PHARMACIST)*** | ***(REGISTRATION NUMBER)*** |
| ..... | ..... |
| **(Signature)** | **(Date Signed)** |

**SECTION C**

## CHANGE OF LOCATION

I.....hereby apply
***(FULL NAME OF APPLICANT)***

to relocate .....
***(NAME OF PHARMACY)***

as a .....Pharmacy Business
***(Retail, Wholesale or Wholesale/Retail)***

to .....
(Location address of proposed premises i.e. H/No., street, Suburb etc.)

**CURRENT LOCATION OF PHARMACY**

.....
(Location address of current premises i.e. H/No., Street, Suburb etc.)

**REASON(S) FOR RELOCATION**

.....
.....
.....
.....
.....
.....

### *BUSINESS PARTICULARS*

| | |
|---|---|
| POSTAL ADDRESS: | TELEPHONE:<br>FAX:<br>E-MAIL: |

### *PROPOSED BUSINESS HOURS*

| MONDAYS - FRIDAYS | SATURDAYS | SUNDAYS |
|---|---|---|
| | | |

| SHAREHOLDERS | DIRECTORS |
|---|---|
| | |
| | |
| | |
| | |

**TO BE COMPLETED BY SUPERINTENDENT PHARMACIST**

**I wish to certify that all the above information is correct to the best of my knowledge and hereby accept to be the Superintendent Pharmacist for the business.**

..... .....
***(NAME OF SUPERINTENDENT PHARMACIST)*** ***(REGISTRATION NUMBER)***

..... .....
**(Signature)** **(Date Signed)**

**SECTION D**

## LOCATION CLEARANCE FORM

*(For applicants changing location)*

NAME OF APPLICANT.....

POSTAL ADDRESS

| | |
|---|---|
| | TELEPHONE:<br><br>FAX:<br><br>E-MAIL: |

**PROPOSED BUSINESS NAME**:.....

**TYPE OF PHARMACY BUSINESS** ☐ RETAIL ☐ WHOLESALE ☐ WHOLESALE/RETAIL

**LOCATION**:.....

***(H/No., Street, Suburb, etc.)***

***DIMENSION OF STORE: LENGTH:..... WIDTH:..... HEIGHT:.....***

***TOWN:..... DISTRICT:..... REGION:.....***

| NAME OF NEAREST PHARMACY/PHARMACIES | RELATIVE DISTANCE FROM PROPOSED LOCATION |
|---|---|
| **1.** | |
| **2.** | |
| **3.** | |

**SKETCH OF LOCATION**

**SECTION E**

## CHANGE OF PHARMACIST(S)

### *SUPERINTENDENT PHARMACIST*

***Fill this section if Superintendent Pharmacist has changed.***

**NAME OF SUPERINTENDENT PHARMACIST**: ……

***FORMER NAME (if any)***…… **REG. NO.:……**

**SIGNATURE:……**

**YEAR OF REG**.:……..

| POSTAL ADDRESS | RESIDENTIAL ADDRESS | TEL:<br>FAX:<br>E-MAIL: |
|---|---|---|

### *(Last 2 places of work of Superintendent Pharmacist)*

| | NAME OF INSTITUTION | POSITION HELD | FROM – TO |
|---|---|---|---|
| Community Pharmacy | | | |
| | | | |
| Hospital | | | |
| | | | |
| Medical Representative | | | |
| | | | |
| Academia | | | |
| | | | |
| Industry | | | |
| | | | |
| Other (Please specify) | | | |
| | | | |

## *FOR OFFICIAL USE ONLY*

| | |
|---|---|
| **NAME OF INSPECTOR OR AUTHORIZED OFFICER** | |
| DATE OF RECEIPT | |
| CODE NUMBER | |

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## *ACKNOWLEDGEMENT SLIP* (*TO BE DETACHED AND GIVEN TO APPLICANT)*

DATE OF RECEIPT

.....

NAME OF INSPECTOR/AUTHORISED OFFICER

.....

| | |
|---|---|
| CODE NUMBER | |
| TIME | |
| SIGNATURE: | |

**OFFICIAL STAMP**