



THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

PHARMACY COUNCIL



NOTICE FOR CHANGE OF MANAGEMENT OR PHARMACEUTICAL PERSONNEL OF A PHARMACY

(Regulation 17(1) of The Pharmacy (Pharmacy Practice and the Conduct of Business of Pharmacy) GN No. 267)

Changes to be Made: Superintendent ☒ Other Pharmaceutical Personnel ☐

A. TO BE COMPLETED BY THE SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL AND OWNER OF THE PHARMACY.

A.1. DETAILS OF THE PHARMACY

Name of the Pharmacy ILALILA PHARMACY Facility Identification Number (FIN) 0103620
 Physical address:
 Street ILALILA CENTER Ward SHIBULA District/Municipal ILEMELA Region MWANZA

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name HABIBU RAMADHAN NEMUA PIN 0102441 Phone 0657 49 2026
 Address 935 Mwanza Email nkemuchabiru@gmail.com

A.3. REASON(S) FOR CHANGE

Payment dispute
 Time frame of notification: (As per Contract) 30 days Signature [Signature] Date 22/08/2025

A.4. OWNER'S DETAILS

Full Name EVARIST BENIPHACE Phone Number 0768494025
 Remarks _____
 Signature _____ Date 22/8/2025

B. TO BE COMPLETED BY THE OWNER ONLY

B.1. NEW SUPERINTENDENT / OTHER PHARMACEUTICAL PERSONNEL

Full Name _____ PIN _____ Phone Number _____ Email _____
 Physical address:
 Street _____ Ward _____ District/Municipal _____ Region _____
 Details of Previous pharmacy:
 Name of Pharmacy _____ FIN _____ District/Municipal _____ Region _____

B.2. QUALIFICATION DOCUMENTS OF THE NEW SUPERINTENDENT / OTHER PHARMACEUTICAL PERSONNEL (To be attached)

- (i) Copies of registration certificate and valid license to practice
- (ii) Contract Agreement/MOU
- (iii) Commitment Letter

C. FOR OFFICIAL USE ONLY

INSPECTION/REGISTRATION OR ZONAL OFFICE

Recommendations _____
 Full Name _____ Designation _____ Signature _____ Date _____

D. NOTE:

Failure to acquire the services of another superintendent/ Other Pharmaceutical Personnel within the mentioned time frame, shall lead to immediate closure of the premises as per Section 43 of the Pharmacy Act Cap 311.

NB: Other pharmaceutical personnel mean any pharmaceutical personnel apart from superintendent.

PHARMACY COUNCIL
(Made under regulation 4(1))



COMPLAINT FORM

To be filled by the complainant and submitted to the Office of the Registrar)

1. Personal Details:

Name: HABIBU R. NKAMIA

Address: 735 MWANZA

Phone number (s): 0657492026

2. Are you the complainant? Yes ☒ No ☐

3. Are you complaining on someone else behalf? Yes ☐ No ☐

If 'Yes' what is your relationship to the someone behalf?

Wife ☐ Husband ☐ Son ☐ Daughter ☐ Sister ☐ Brother ☐ etc.

4. Details of the pharmaceutical personnel PROPRIETOR OF ILALILA PHARMACY
Full name of each pharmaceutical personnel you are complaining about
The address of each pharmaceutical personnel work at (if you know) or the address where you were attended.

EVARIST BOMPHACE, Address 735, ILALILA, MWANZA
Phone NO 0743574591 or 0765494025

5. Give details of your complaint Please describe your complaint, and state exactly what happened and, if possible include dates, time and place of incident

About payment dispute, and poor relationship about business.

6. Do you have any documents (for example, letters or records) which might back up your complaint? If you do, please attach copies and list them below. If needed, we will return all original documents after taking copies.

7. Are there any other people who witnessed the acts you are complaining about? If yes, please give their names below, and how they were involved.

8. Are those people be prepared to make written statements? Yes [] No []

9. We are always try to deal with most complaints through correspondence but, if it becomes necessary, are you prepared to be a witness at an inquiry of your complaint? Yes [] No []

10. Have you complained to any other organization about this matter (example where the pharmaceutical personnel work?). If 'Yes', please say which organization you have lodged your complaint to.

11. Give us brief details of what happened to your complaint, and send us copies of any letters between you and that organization.

12. Declaration

I hereby certify that the information I have given in this form is complete and accurate, and I solemnly make this declaration, conscientiously believing the same to be true.

Name: HABIBU R. NKAMIA

Signature: [Signature]

Date: 22/8/2025