LILIAN ELIASSA

P.O BOX 33335

DAR ES SALAAM

TANZANIA

eliassalilian@gmail.com

0763999817

MSAJILI

BARAZA LA FAMASI

P.O BOX 1277

DODOMA

TANZANIA

YAH: KUOMBA KUONDOLEWA USIMAMIZI WA ZEST FAUZAN PHARMACY-MBEYA

Kichwa cha habari cha husika.

Mimi mfamasia LILIAN ELIASSA mwenye PIN 0102861 nasimamia famasi ya ZEST FAUZAN yenye FIN 0200290 iliyopo MBEYA. Ninapenda kutoa taarifa ya kuhama kutoka mkoa wa MBEYA na kuhamia mkoa wa DAR ES SALAAM ,hivyo naomba kusitisha mkataba wangu na famasi tajwa nilitoa taarifa yam domo na baadae ya maandishi kwa mmiliki lakn hakuonesha ushirikiano wa kusaini form namba 17.

Kwa barua hii naomba kutoa taarifa ya kusitisha mkataba baina yangu na Zest Fauzan famasi ndani ya siku 30 kama ilivyoinishwa kwenye fomu na kumpa mmliki nafasi ya kuingia makubaliano ya usimamizi na mfamasia mwingne,Licha ya form kutokusainiwa na mmiliki kwani nimefanya jitihada za kumpata ila zimeshindikana.

Naambatanisha fomu namba 17 Natumaini ombi langu litafanyiwa kazi kwa wakati asante.

Wako katika ujenzi wa Taifa

Lilian Eliassa

PCF. 17

PHARMACY COUNCIL

NOTIFICATION FOR CHANGE OF MANAGEMENT OF A PHARMACY
(Made under regulation 17(1) Pharmacy (Pharmacy Practice and the Conduct of Business of Pharmacy) GN No. 267)

A. **TO BE COMPLETED BY THE SUPERINTENDENT AND OWNER**

DETAILS OF THE PHARMACY
Name of the pharmacy....Zest Fauzan Pharmacy.....
Physical address:
Street.....SINDE.....Ward.....SINDE.....
District/Municipal.....MBEYA C.C.....
Region.....MBEYA.....

DETAILS OF SUPERINTENDENT
Name.....LILIAN ELIASSA.....
Registration Number.....0102861.....
Phone.....0763999817.....
Address.....eliassalilian@gmail.com (DAR-ES SALAAM)

REASON(s) FOR CHANGE
.....Change in workplace from Mbeya to.....
.....Dar es salaam.....

TIME FRAME: (Notify Registrar the time frame as per Contract)
.....30 days.....
Signature.....
Date.....30/09/2024.....

OWNER REMARKS
.....
Name.....
Phone Number .....
Signature.....
Date.....

FOR **OFFICE USE ONLY**

INSPECTION/REGISTRATION DEPARTMENT OR ZONAL MANAGER

Recommendations.....
Name.....Designation.....Signature.....
Date.....

B. **TO BE COMPLETED BY THE OWNER ONLY**

NEW SUPERINTENDENT

Name of Superintendent .....
Physical address:
Street.....
Ward.....
District/Municipal.....
Region.....
Contacts of previous Superintendent.....
Email of previous Superintendent.....

QUALIFICATION DOCUMENTS OF THE NEW SUPERINTENDENT (To be attached)

(i) copies of registration certificate and valid license to practice
(ii) Contract Agreement
(iii) Commitment Letter

REASONS FOR CHANGING THE MANAGEMENT

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C. **FOR OFFICE USE ONLY**

INSPECTION/REGISTRATION OR ZONAL

Recommendations.....
.....
Name.....Designation.....Signature.....
Date.....

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