Flora Valerian Sulley,
S.l.p 32,
Namtumbo,
19/03/2025.

Msajili,
Baraza la Famasi,
S. L. P. 453,
MBEYA.

Yah: **MAOMBI YA KUTOLEWA KUSIMAMIA AST PHARMACY FIN:0102982.**

Rejea mada tajwa hapo juu.

2. Mimi Flora Valerian Sulley, Mfamasia mwenye PIN:0101840 naomba kutolewa kusimamia AST Pharmacy kwa sababu mkataba umeisha na mmiliki amekuwa akinisumbua kusaini fomu.

3. Pamoja na barua hii, naambatisha nakala ya fomu ya kubadilisha Mfamasia ambayo nimesaini mimi.

Naomba kuwasilisha,

Flora Valerian Sulley.
Mfamasia.

PCF. 17

THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

PHARMACY COUNCIL

NOTIFICE 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..AST PHARMACY..Facility Identification Number (FIN)..0102982..

Physical address:

Street..MAJENGO..Ward..MAJENGO..District/Municipal..SONGEA MC..Region..RUVUMA..

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name..FLORA VALERIAN SULLEY..PIN..0101840..Phone..0769298630..

Address..P. O. BOX 32 NAMTUMBO..Email..florasulley4@gmail.com..

A.3. REASON(s) FOR CHANGE

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ATOMATIC TERMINATION (EXPIRY OF A TERM FIXED)

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Time frame of notification: (As per Contract) ..—..Signature..Sulley..Date..19/02/2025..

A.4. OWNER'S DETAILS

Full Name.....Phone Number.....

Remarks.....

Signature..... Date.....

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.