



Jamhuri ya Muungano wa Tanzania

United Republic of Tanzania

Pharmacy Council

Exchequer Receipt

Stakabadhi ya Malipo ya Serikali

Receipt No : 924008225434928

Received from : NIRVANA PHARMACY

Amount : 50,000.00

Amount in Words : Fifty Thousand TZS And Zero Cent(s) Only

Outstanding Balance : 0.00

In respect of	Item Description(s)	Item Amount
: 142202540104 - Application for change of name/ ownership - CHANGE OF OWNERSHIP		50,000.00

Total Billed Amount : 50,000.00 (TZS)

Bill Reference : 16215008245734657872

Payment Control Number : 991620234046

Payment Date : 2024-01-08 16:02:26

Issued by : Zena Mango

Date Issued : 2024-01-08 16:10:55

Signature

Government Payment Gateway © 2017 All Rights Reserved (GePG)



1620234046
The UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

PHARMACY COUNCIL

Alipie 50,000/-

PCF. 17

08/01/2024



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 NIRVANA PHARMACY Facility Identification Number (FIN) 0102395
Physical address:
Street Mogoro road Ward matete District/Municipal Ubungu Region DAR

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name ASHA ALLY PIN 0103505 Phone 0783762810
Address ASHA ALLY Email asha.ally.372@gmail.com

A.3. REASON(S) FOR CHANGE

CHANGE OF BUSINESS OWNERSHIP
Time frame of notification: (As per Contract) Signature Date

A.4. OWNER'S DETAILS

Full Name JISENA KUSHOKA Phone Number 0766711655
Remarks PR Date 08/01/2024
Signature JISENA KUSHOKA

B. TO BE COMPLETED BY THE OWNER ONLY

B.1. NEW SUPERINTENDENT / OTHER PHARMACEUTICAL PERSONNEL

Full Name JISENA KUSHOKA PIN 0103304 Phone Number 0766711655 Email kushokajisenar200@gmail.com
Physical address:
Street Kumara Ward Kumara District/Municipal Ubungu Region DAR
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

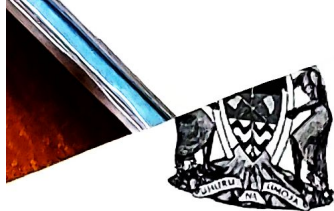
INSPECTION/REGISTRATION OR ZONAL OFFICE

Recommendations Designation Signature Date
Full Name

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.



THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

PHARMACY COUNCIL

DECLARATION FORM FOR PHARMACY OWNERS WHO ARE
PHARMACEUTICAL PERSONNEL

(Made under Section No. 43 (1) (a) of the Pharmacy Act 2011)

Cadre: Pharmacist ☒ Pharm. Technician ☐ Pharm. Assistant ☐ Pharm. Dispenser ☐Owner's Responsibilities: Superintendent ☒ Other Pharmaceutical Personnel ☐I JILENA KUSHOKA with Personal Identification Number
(PIN) 0103304 of Year 2022, residing at UBUNGU district, in DAR
Region, Hereby declares that:I am a Sole proprietor/shareholder of pharmaceutical business named NIRVANA PHARMACY
, with Facility Identification Number (FIN) 0102395 of year _____, located at UBUNGU
District, DAR Region with a Business Tax Identification Number (TIN) 170-912-144
(TIN Certificate to be attached)***.As the owner of the named pharmacy, I shall abide to all obligations as a proprietor and I will
comply with the Laws, Regulations, Guidelines and Standards prescribed by the Council and
other relevant authorities in running the business of a pharmacist.In case I fail to adhere to these legislations, I shall be responsible and liable for being
subjected to a professional misconduct.Phone: 0766711655 Email Address: kushokajilerena1200@gmail.comSignature: [Signature] Date: 08/01/2024NOTE: This form shall be a substitute of the **Contract agreement** to pharmacists / Other Pharmaceutical Personnel who
owns a pharmacy at same time they are superintendent/practice as other pharmaceutical personnel in the pharmacy.In this case, the owner shall abide to obligations/ scope of practice as stated under The Pharmacy (Pharmacy Practice and
the Conduct of Business of Pharmacy) Regulations, 2020.

*** Mandatory