Jamhuri ya Muungano wa Tanzania

United Republic of Tanzania

Pharmacy Council

Exchequer Receipt

Stakabadhi ya Malipo ya Serikali

Receipt No	: **924348296961722**
Received from	: john edward mikundi
Amount	: 400,000.00
Amount in Words	: Four Hundred Thousand TZS And Zero Cent(s) Only
Outstanding Balance	: 0.00

In respect of	Item Description(s)	Item Amount
142201410182 - Registration Whole sale Pharmacy - 16217341243941192710	**400,000.00**	
	Total Billed Amount :	**400,000.00 (TZS)**

Bill Reference	: 16217341243941192710
Payment Control Number	: ***991620283015***
Payment Date	: **2024-12-13 19:58:17**
Issued by	: Zena Mango
Date Issued	: 2025-01-23 09:13:45
Signature	:

Jamhuri ya Muungano wa Tanzania

United Republic of Tanzania

Pharmacy Council

Exchequer Receipt

Stakabadhi ya Malipo ya Serikali

Receipt No	: **925023305614681**
Received from	: MAJIMOTO PHARMACY
Amount	: 650,000.00
Amount in Words	: Six Hundred Fifty Thousand TZS And Zero Cent(s) Only
Outstanding Balance	: 0.00

In respect of	Item Description(s)	Item Amount
: *142201410182 - Registration Whole sale Pharmacy - BUSINESS PERMIT AND PROFESSIONAL FEE*	**650,000.00**	
	Total Billed Amount :	**650,000.00 (TZS)**

Bill Reference	: 16210017252807516356
Payment Control Number	: ***991620296875***
Payment Date	: **2025-01-23 08:23:30**
Issued by	: Zena Mango
Date Issued	: 2025-01-23 09:14:35
Signature	:

PHARMACY COUNCIL

APPLICATION FOR REGISTRATION OF PREMISES
(Section 34 of the Pharmacy Act, 2011)

Registrar,
Pharmacy Council,
P. O. Box 31818,
Dar es Salaam.

SECTION A: APPLICANT INFORMATION

I / We hereby apply for registration of my/our existing/ new premises in accordance with the Pharmacy Act, 2011

1. The proposed name of the premises is... MAJIMOTO PHARMACY
2. Have you registered your Business name with BRELA? YES / NO provide registration No. .....
3. Type of ownership: Sole proprietorship... SOLE PROPRIETORSHIP / Partnerships ..... / Corporations..... / Joint Ventures.....
4. Name of contact person ... JOHN EDWARD MIKUNDI .....
5. Postal address. 245 ... Tel, No. 0767277815 Fax..... email.....
6. Full name(s) of Partner(s) and Directors(s) ... JOHN EDWARD MIKUNDI .....

   .....

   Name: ..... Qualification: ..... I.D No. .....

   Name: ..... Qualification: ..... I.D No. .....

   Name: ..... Qualification: ..... I.D No. .....
7. Physical address of the proposed area: Street... MLUNGA ... Ward.. MAJIMOTO ... District... MLELE ... Region... KATAVI ... Plot No.....
8. Premises to be registered for the business of ... WHOLESALE & RETAIL .....

9. The business will be under the supervision of a registered superintendent (Full Name) NENE - BUJIKU

Whose qualification is B. PHARM and his /her Reg.No./ PIN 010166 of Year, 2016

(Please attach a copy of registration Certificate and acceptance / commitment letter from the proposed superintendent)

10. The Superintendent pharmacist will be under the assistant of a recognized pharmaceutical personnel (Full name) LYDIA KALIMA

Whose qualification is DIPLOMA And his / her Enroll/List.No./PIN 0405588 of Year 2021

(Please attach a copy of enrolment/enlist/dispenser Certificate and acceptance OR commitment letter from the proposed superintendent)

11. Business Commencement Date.....

12. Required attachment to be submitted with this form are:
    a. Memorandum
    b. A copy of lease agreement/ title deed
    c. Certificate of Registration from BRELA (if available)
    d. Copy of contract agreement from superintendent pharmacist
    e. Copy of contract agreement from either enrolled/enlisted or dispenser
    f. Copy of Directors/ Partners ID

13. If my/our premises is registered and licensed I/We shall keep it in hygienic condition and good state of repair as required under the above mentioned Act and Regulations made there under.

14. I/we have not been convicted of any offence relating to any provision of the Pharmacy Act, 2011 and Regulations made there under or any other written law related to the business being applied for within 12 months immediately preceding this application and have not been disqualified from holding a license/certificate and my license is/is not suspended.

N.B. False declaration constitutes an offence.

Date 14/12/2024

Signed.....
Applicant

SECTION B: DISTRICT/MUNICIPAL/REGIONAL/PHARMACY COUNCIL INSPECTOR's REMARKS

(Delete which inapplicable)

(In case there is no District Inspector this part should be filled by Regional Inspector)

I, Mr./Mrs./Ms./Dr./Prof. EMMANUEL E. KALAN District/Municipal/Regional/PC Inspector of Postal address.....245 - MPANDA.....hereby certify that, I have inspected the above mentioned premises in Section A as per attached inspection checklist and found that it complies/does not comply with standards prescribed for registration of premises.

Please give reason(s) if it does not comply:

It is Complied

Name of Inspectors(s)	Signatures & stamp	Date
1. EMMANUEL E. KALAN		14/12/2024
2. FURAHA S CHAULA		14/12/2024

FOR OFFICIAL USE ONLY

Fees TZS..... Receipt No.....of.....

Registration granted/not granted because.....

.....

Registration No..... Approved by Name: .....

Signature: .....

Designation: .....

I.D Number: .....

Date: .....

....

Date Signature of Registrar and stamp.