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..Maja...pharmacy.....Facility Identification Number (FIN).0.1.0.3.3.3.1

Physical address:

Street.buzuruga..Ward..Nyakato.....District/Municipal..Ilemela.....Region.Mwanza

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name.Eliabu...Masasi...Jackson.....PIN.04.07.185..Phone...0757782145.....

Address.S.L.p..424.....Email.Eliabyjackson94@gmail.com.....

A.3. REASON(s) FOR CHANGE

.Shifting...to..another..pharmacy.....

.....

Time frame of notification: (As per Contract) .30.days..Signature..Ejackson..Date.19.09.2025

A.4. OWNER'S DETAILS

Full Name..MAJALIWA SELEMANI.....Phone Number..0764665926.....

Remarks..Allowed to transfer to another phamacy.....

Signature..sele.... Date.18/09/2025

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.

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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 MACHINJIONI PHARMACY Facility Identification Number (FIN) 0100895

Physical address:

Street MIANDU Ward MACHINJIONI District/Municipal NYAMAGANA Region MWANZA

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name BLASIO HUMAN BLASIO PIN 0405142 Phone 0759494107

Address MWANZA TANZANIA Email blumanu.26@gmail.com

A.3. REASON(s) FOR CHANGE

FAILURE TO PERFORM CONTRACTUAL OBLIGATIONS.

(30 days)

Time frame of notification: (As per Contract) ~~19/09/2025~~ Signature [signature] Date 19/09/2025

A.4. OWNER'S DETAILS

Full Name MARY RAPHAEL NLEWA Phone Number 0784525553

Remarks Agree

Signature [signature] Date 19/09/25

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)

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