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 SELEKA PHARMACY Facility Identification Number (FIN) [illegible]

Physical address

Street STAMICO Ward [illegible] District/Municipal GEITA Region GEITA

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name [illegible] PIN 0103893 Phone 0745 048050

Address P.O. BOX 505 Email [illegible]

A.3. REASON(s) FOR CHANGE OWNER OF PHARMACY FAILED TO PAY MY MONTHLY SALLARIES FOR [illegible] CONSECUTIVE MONTH

Time frame of notification (As per Contract) 1 MONTH Signature M. Dollo Date 18/08/2025

A.4. OWNER'S DETAILS

Full Name [illegible] Phone Number 0747-352727

Remarks

Signature Date 18/08/2025

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.

PHARMACY COUNCIL

(Made under regulation 4(1))

COMPLAINT FORM

To be filled by the complainant and submitted to the Office of the Registrar)

1. Personal Details:
   Name: HADULA DOTTO ....
   Address: P O Box 508, GEITA ....
   Phone number (s): 0748-243252 ....
2. Are you the complainant? Yes [✓] No [ ]
3. Are you complaining on someone else behalf? Yes [ ] No[ ]

   If 'Yes' what is your relationship to the someone behalf?

   Wife [ ] Husband [ ] Son [ ] Daughter [ ] Sister [ ] Brother [ ] etc.
4. Details of the pharmaceutical personnel
   Full name of each pharmaceutical personnel you are complaining about
   The address of each pharmaceutical personnel work at (if you know) or the address where you were attended.
   ....
   ....
   ....
   ....

5 Give details of your complaint Please describe your complaint, and state exactly what happened and, if possible include dates, time and place of incident

OWNER OF PHARMACY FAILED TO PAY MY MONTHLY SALARIES
FOR TWO CONSECUTIVE MONTH

6. Do you have any documents (for example, letters or records) which might back up your complaint? If you do, please attach copies and list them below. If needed, we will return all original documents after taking copies.

7 Are there any other people who witnessed the acts you are complaining about? If yes, please give their names below, and how they were involved.

8. Are those people be prepared to make written statements? Yes [ ] No [ ]

9. We are always try to deal with most complaints through correspondence but, if it becomes necessary, are you prepared to be a witness at an inquiry of your complaint? Yes [ ] No [ ]

10. Have you complained to any other organization about this matter (example where the pharmaceutical personnel work?). If 'Yes', please say which organization you have lodged your complaint to.

11. Give us brief details of what happened to your complaint, and send us copies of any letters between you and that organization.

12. Declaration
I hereby certify that the information I have given in this form is complete and accurate, and I solemnly make this declaration, conscientiously believing the same to be true

Name: MADELLA DOITO
Signature: M. Doito
Date: 10/08/2025