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: NEIGHBOR'S PHARMACY Facility Identification Number (FIN): 030037A

Physical address:

Street: MITIMIREFU Ward: MJINI District/Municipal: SHINYANGA Region: SHINYANGA

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name: GEORGE KOMANYA SAGENGE PIN: 0103686 Phone: 0742 115 269

Address: SHINYANGA Email: komanyageorge70@gmail.com

A.3. REASON(s) FOR CHANGE

As a Pharmacist I need to superintend My own pharmacy

Time frame of notification: (As per Contract) one month Signature: G. Komanya Date: 08/07/2025

A.4. OWNER'S DETAILS

Full Name: EDWARD LUKANYA KARANZA Phone Number: 0769 617 645

Remarks: The superintendent need to superintend his own pharmacy

Signature: [signature] Date: 08/07/2025

B. TO BE COMPLETED BY THE OWNER ONLY

B.1. NEW SUPERINTENDENT / OTHER PHARMACEUTICAL PERSONNEL

Full Name: EDWARD LUKANYA KARANZA PIN: 0101652 Phone Number: 0769617645 Email: lukanyaedward@gmail.com

Physical address:

Street: MITIMIREFU Ward: MJINI District/Municipal: SHINYANGA Region: SHINYANGA

Details of Previous pharmacy:

Name of Pharmacy: KISHAPU PHARMACY FIN: 030052 District/Municipal: KISHAPU Region: SHINYANGA

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.

PCF 20

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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 EDWARD LUKANYA KABANZA with Personal Identification Number (PIN) 0101652 of Year 2018, residing at SHINYANGA district, in SHINYANGA MC Region, Hereby declares that:

I am a Sole proprietor/shareholder of pharmaceutical business named NEIGHBOR'S PHARMACY, with Facility Identification Number (FIN) 0300374 of year 2020, located at SHINYANGA District, SHINYANGA MC Region with a Business Tax Identification Number (TIN) 132296972 (**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: 0769617645 Email Address: Lukanyaedward@gmail.com

Signature: [signature] Date: 21/08/2025

NOTE: 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**