MERCY YOHANA MARIKI

S.L.P,

MBEYA.

03/09/2025.

BARAZA LA FAMASI,

S.L.P,

ARUSHA.

Ndugu,

YAH: KUOMBA KUSITISHA USIMAMIZI WANGU KATIKA DUKA LA DAWA LA BELCALIS.

Rejea kichwa cha barua tajwa hapo juu.

Mimi ni Mercy Yohana Mariki (PIN 0103899). Mfamasia msimamizi wa duka la dawa la Belcalis.

Ninaomba kusitisha usimamizi wangu katika duka la dawa la Belcalis kwa sababu kwa sasa nimehamia Mbeya hivyo itakua ngumu kuendelea kusimamia duka hili la dawa la Belcalis, na mmiliki ameshindwa kuonyesha ushirikiano katika kujaza taarifa kwa ajili ya kusitisha usimamizi.

Ni maombi na matumaini yangu kua ombi langu litafanyiwa kazi.

Wako katika utumishi

.....

MERCY YOHANA MARIKI.

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. BELCALIS PHARMACY ..... Facility Identification Number (FIN). 0103563

Physical address:

Street. NAMAYAN ..... Ward. KIRANYI ..... District/Municipal. ARUSHA DC .... Region. ARUSHA

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name. MERCY YOHANA MARIKI ..... PIN 0103899 .. Phone. 0745170070 .....

Address. P.O BOX, MBEYA. ..... Email. 18mercy98@gmail.com .....

A.3. REASON(s) FOR CHANGE

There is difficult in supervision issue due to location as I have transfered to Mbeya.

Time frame of notification: (As per Contract) .. 30 days. .... Signature. ~~.....~~ .. Date. 03/09/2025 .....

A.4. OWNER'S DETAILS

Full Name. FABIAN WENCESLAUS NTALO ..... Phone Number. 0783008149 .....

Remarks. Owner does not show cooperation. .....

Signature..... Date. 03/09/025

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.