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 MEDICARE PHARMACY Facility Identification Number (FIN) 0100866

Physical address:

Street UN- ROAD Ward UPANGA District/Municipal ILALA Region DARESALAAM.

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name MOHAMMED MAKURU PIN 1416 Phone 0754488064

Address DAR ES SALAAM. Email

A.3. REASON(s) FOR CHANGE

No longer interested working with him.

Time frame of notification: (As per Contract) 7 days Signature [signature] Date 06/09/2024.

A.4. OWNER'S DETAILS

Full Name NAJAT KASSIM MOHAMED Phone Number 0716163630

Remarks

Signature [signature] Date 26/08/2024.

B. TO BE COMPLETED BY THE OWNER ONLY

B.1. NEW SUPERINTENDENT / OTHER PHARMACEUTICAL PERSONNEL

Full Name MARK AGUSTINO PIN 010621 Phone Number 0766627055 Email Markuskanihe@gmail.co[m]

Physical address:

Street TEGETA Ward District/Municipal KINONDONI Region DARESALAAM

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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THE UNITED REPUBLIC OF TANZANIA

THE PHARMACY COUNCIL

№ 00001695

CERTIFICATE OF FULL REGISTRATION

(Section 15 of the Pharmacy Act, 2002)

I, Mark Augustino

I hereby certify that the following is a true extract from the entry in the Register relating to fully registered pharmacist details in respect of whom are set out below.

Registration No.	Registration Date	Date of Birth	Nationality	Address	Qualification	Place and Date of Qualification
0627	7th Oct. 2009	7th May, 1979	Tanzanian	P.O. Box 1008 Arusha	Bachelor of Pharmacy	Muhimbili University of Health and Allied Science 2007

Date 6TH NOVEMBER, 2009

REGISTRAR

NOTES: 1) This certificate affords immediate evidence of registration. In due course the name of the Pharmacist will be published in the list of registered Pharmacists published annually by the Council and reference should thereafter be made to the current Published list for evidence as to continue registration

2) This Certificate is not an evidence of the identity of its holder of the named above and must not be used as such

GP-Dsm

AGREEMENT TO OPERATE A BUSINESS OF PHARMACIST

THIS AGREEMENT is made on this ....01..... Day of ..SEPT. 2024.....Between .....(hereinafter referred to as **"the PROPRIETOR)** on the one part and ..MARK AUGUSTINO ..MEDGARE .....Pharmacy on the other part.

WHEREAS the parts intend to carry on a business of pharmacist (the retail pharmacy) as provided under the provisions of the Pharmacy Act). (hereinafter referred to as "the Act). Since a business of a pharmacist shall be under the management of the **SUPERINTENDENT** who is a **PHARMACIST** as provided under the Act.

NOW THEREFOR the proprietor and me the pharmacist ("hereinafter referred to as **SUPERINTENDENT"** agree to run the terms and condition as set below.

1. **THE PROPRIETOR** shall be able to meet its expenses
2. From funds generated by the pharmacy and shall supply adequate fund to meet the following expenses;
   a) Pay monthly salary of 800,000/= .....payable monthly to **THE SUPERITENDENT** in discharging functions. The salary shall be net of any payable taxes and or deductible employment benefits and shall be paid no later than 1st day of following month.
   b) The cost of rehabilitating and maintaining the premises as the same as modern pharmacy.
   c) Any other cost necessary or incidental to the running the pharmacy.
3. All personnel of the **PROPRIETOR** shall be under the control of the **SUPERINTENDENT.** However the power of hire and fire as well as disciplining these employees other than technical personnel shall be lie under the proprietor.
4. The agreement shall be for twelve (12) months year to year basis unless one of the parties given a written notice of unspecified period of time (Automatic termination) of his intention to remove himself from the business of a pharmacist and the copy of this notice shall be submitted to the registrar of the pharmacy council as soon as possible.
5. The agreement may be terminated at anytime by mutual agreement or consent between the parties when they find it appropriate that agreement by terminated.

6. The **PROPPRIETOR** shall meet the cost of drawing up this agreement.

7. **Commencement of supervision**
The superintendent shall commence management and supervision of the above named pharmacy on the ....01..... Day of ..SEPT. 2024.....

IN WITNESS WHEREOF the **PROPRIETOR** and **THE SUPERINTENDENT** have executed this agreement on the date and in manner hereinafter appearing.

SIGNED and DELIVERED
By the said .....YASIR M. KACYANGO.....
Who is known to me personally/
Introduce to me by ...MUHAMMAD S. SAID.....
This ....09.....Day of ....06.....Year 2024.

.....HR.....
PROPRIETOR

Before me :

Name .....MARY NYASEBWA.....
Title .....ADVOCATE.....
Signature .....
Date .....9/06/2024.....

Mary Nyaseibwa Box 1446 Dar es Salaam Advocate, Notary Public & Commissioner for Oaths

SIGNED and DELIVERED
By the said .....MARK AUGUSTINO.....
Who is known to me personally/
Introduce to me by ROZINA MALAMSHA.....
This ...01.....Day of..SEPT.....Year 2024.

.....
SUPERINTENDENT

Before me :

Name .....MARY NYASEBWA.....
Title .....ADVOCATE.....
Signature .....
Date .....9/06/2024.....

Mary Nyaseibwa Box 1446 Dar es Salaam Advocate, Notary Public & Commissioner for Oaths

WIZARA YA AFYA, MAENDELEO YA JAMII, JINSIA, WAZEE NA WATOTO

BARAZA LA FAMASI

FOMU YA KUKIRI KUTEKELEZA MAJUKUMU YA MWANATAALUMA WA DAWA KWENYE MAJENGO YA KUTOLEA HUDUMA YA DAWA
(kutoka katika Kifungu No. 44 (1) (a) cha Sheria ya Famasi)

SEHEMU YA KWANZA: - TAARIFA ZA MWANATAALUMA

☐ **MFAMASIA** ☐ **FUNDI DAWA SANIFU** ☐ **FUNDI DAWA MSAIDIZI** ☐ **PHARM. DISP**

1. Jina la mwanataaluma..MARK AUGUSTINO.. PIN ..010627..
2. Namba ya simu..0766627055.. barua pepe ..markuskausishe@gmail.com
3. Tarehe ya mwisho kuhuisha jina *(Retention)*..DECEMBER 2023.
4. Je, umehuisha taarifa zako kwenye mfumo kupitia tovuti ya baraza la famasi? (http://196.45.42.57/pcmis.data/view/modules/registration/pharmacist-signup.php) ☑ NDIYO, Stakabadhi Na. ..... ☐ HAPANA

SEHEMU YA PILI: - KUKIRI KWA MWANATAALUMA:

Mimi..MARK AUGUSTINO.. mwenye taaluma ya dawa ngazi ya ..STANDARD.. nakiri kwamba nitafanya kazi yangu ya kitaaluma katika jengo la kutolea huduma ya dawa liitwalo ..MEDCARE PHARMACY.. FIN ..0100866.. lililopo katika Wilaya ya ..ILALA.. Mkoani ..DAR-ES-SALAAM..

Sahihi ..... Tarehe ..28/08/2024..

Uthibitisho wa Mfamasia wa Halmashauri

Nadhibitisha kwamba mwanataaluma tajwa ni **miongoni/ si miongoni** mwa wanataaluma waliopo katika halmashauri ninayosimamia

Muhuri KNY: DMO

Jina na Sahihi ROMANA MANAWE, ... **Tarehe**..28/08/2024..

SEHEMU YA TATU: - UTHIBITISHO WA MAKAZI:

Ithibitishwe na: Afisa Mtendaji

Jina la mtendaji (Kata)..PETER S. MHALUKA.. Kata ya..GOBA..

Nathibitisha kwamba Ndugu..MARK AUGUSTINO..anaishi langu mtaa/~~kijiji~~..TEGETA A.., kuanzia mwaka..2017..

Muhuri Mtendaji

30 AUG 2024

KATA YA GOBA

Sahihi Afisamtendaji ..... **Tarehe** 30/08/2024