Jamhuri ya Muungano wa Tanzania

United Republic of Tanzania

Pharmacy Council

Exchequer Receipt

Stakabadhi ya Malipo ya Serikali

Receipt No	**: 923362223080392**
Received from	: BLINDA PHARMACY
Amount	: 50,000.00
Amount in Words	: Fifty Thousand TZS And Zero Cent(s) Only
Outstanding Balance	: 0.00

In respect of	Item Description(s)	Item Amount
: *142202540104 - Application for change of name/ ownership - CHANGE OF MGT*		**50,000.00**

Total Billed Amount : 50,000.00 (TZS)

Bill Reference	: 16209362232040160277
Payment Control Number	: ***991620231388***
Payment Date	**: 2023-12-28 09:33:39**
Issued by	: Zena Mango
Date Issued	: 2023-12-28 10:22:51
Signature	: .....

PHARMACY COUNCIL

99162023138 8 Alipie 50,000/=

Bel:

28/12/23

PCF. 17

PHARMACY COUNCIL

NOTIFICATION FOR CHANGE OF MANAGEMENT OF A PHARMACY

(Made under regulation 17(1) Pharmacy (Pharmacy Practice and the Conduct of Business of Pharmacy) GN No. 267)

A. **TO BE COMPLETED BY THE SUPERINTENDENT AND OWNER**

DETAILS OF THE PHARMACY

Name of the pharmacy..... BILIDA PHARMACY .....

Physical address:

Street. MLANDIZI BUS STOP ..... Ward. MLANDIZI .....

District/Municipal... KIBAHA .....

Region.. PWANI .....

DETAILS OF SUPERINTENDENT

Name... MATHEW J. CHOAJI .....

Registration Number. 010250 .....

Phone... 0710575559 .....

Address... UBUNGO, DAR ES SALAAM .....

REASON(s) FOR CHANGE

..... END OF CONTRACT AND CHANGE OF ADDRESS .....

TIME FRAME: (Notify Registrar the time frame as per Contract)

.....

Signature... M. Choaji .....

Date.. 10/12/2023 .....

OWNER REMARKS

.....

Name SHESHA ELIKUZUMA ELIAMINI .....

Phone Number 0675 326505 .....

Signature..... .....

Date..... 20-12-2023 .....

FOR **OFFICE USE ONLY**

INSPECTION/REGISTRATION DEPARTMENT OR ZONAL MANAGER

Recommendations.....

Name.....Designation.....Signature.....

Date.....

B. **TO BE COMPLETED BY THE OWNER ONLY**

NEW SUPERINTENDENT

Name of Superintendent ..SHUKURANI M. CHIMALE.....
Physical address:
Street..MSUFINI.....
Ward..MLANDIZI.....
District/Municipal..KIBAHA DC.....
Region..COAST REGION.....
Contacts of previous Superintendent..0710575559.....
Email of previous Superintendent..choajimathew@yahoo.com.....

QUALIFICATION DOCUMENTS OF THE NEW SUPERINTENDENT (To be attached)

(i) copies of registration certificate and valid license to practice
(ii) Contract Agreement
(iii) Commitment Letter

REASONS FOR CHANGING THE MANAGEMENT

..END OF CONTRACT AND CHANGE OF ADDRESS.....

C. **FOR OFFICE USE ONLY**

INSPECTION/REGISTRATION OR ZONAL

Recommendations.....
.....
Name.....Designation.....Signature.....
Date.....

NOTE;
Failure to acquire the services of another superintendent within the mentioned time frame, shall lead to immediate closure of the premises as per Section 43 of the Pharmacy Act Cap 311.