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... 2AM 2AM PHARMACY.....
Physical address:
Street..... KARIAKOO ..... Ward..... ILALA .....
District/Municipal..... ILALA .....
Region..... DAR ES SALAAM .....

DETAILS OF SUPERINTENDENT

Name..... SHWENA CHIPUKIMBO .....
Registration Number..... 0103098 .....
Phone..... 0765496723 .....
Address.. MAGOMENI DAR ES SALAAM .....

REASON(s) FOR CHANGE

..... NO PAYMENT .....
.....

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

..... 30 DAYS .....
Signature.....
Date..... 06/12/2023 .....

OWNER REMARKS

..... THE OWNER DOES NOT WANT TO SIGN .....
Name.....
Phone Number .....
Signature.....
Date.....

FOR **OFFICE USE ONLY**

INSPECTION/REGISTRATION DEPARTMENT OR ZONAL MANAGER

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