



## THE UNITED REPUBLIC OF TANZANIA

## MINISTRY OF HEALTH

## PHARMACY COUNCIL



## NOTICE 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... KIOJA ..... Facility Identification Number (FIN) 0102121  
 Physical address:  
 Street... MAWAZO ..... Ward... SOWETO ..... District/Municipal... MOSHI TOWN ..... Region... KILIMANJARO

## A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name... GOODLUCK RAYMOND ..... PIN 0102439 ..... Phone 0767010845  
 Address... P.O. BOX 481 MOSHI ..... Email... gudraym@gmail.com

## A.3. REASON(S) FOR CHANGE

We are planning to make changes in the management following the expiry of the pharmacist's contract this month as he has been unable to take up a new contract due to personal commitment that prevents him from fulfilling the duties.  
 Time frame of notification: (As per Contract) 30 days ..... Signature [Signature] ..... Date 24/09/2025

## A.4. OWNER'S DETAILS

Full Name... DR. GEORGINA ALOYCE MUKA ..... Phone Number 0717518065  
 Remarks... Presented well  
 Signature [Signature] ..... Date 5/11/2025

## 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.