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17 march 2025
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MSAJILI BARAZA LA FAMASI
S.L.P 1277
DODOMA

Yah: Taarifa ya kusitisha usimamizi wa Famacy yenye usajili wa (FIN 0300487)

Ndugu,

Husikana ombi tajwa hapo juu

Kufuatia barua yako yenye kumbukumbu namba NA: CA.313/329/01E/20. Nakiri kuto kutoa taarifa ya nia ya kusitish ausimamizi fa kitaaluma wa pharmacy tajwa hapo juu kutokana na sababu zilizo njee ya uwezo wangu Na naahidi kujirekebisha kwa kufata sharia na kanuni za taaluma na nchi kwa ujumla Hivo ninaomba kutoa taarifa juu ya nia ya kusitisha usimamizi wa kachiki pharmacy iliyoko wilayani tunduru. Kwasasa nimehamishia makazi yangu mkoani Dar es salaam kikazi hivo naomba kusitisha shughuli za usimamizi wa pharmacy tajwa hapoju ifikapo tarehe 1 mwezi wa saba 2025.

Wako mtaaluma

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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 KACHIKI PHARMACY Facility Identification Number (FIN) 6300487

Physical address:

Street LAMBAI (A) Ward MBUNGOTI MADARAKI District/Municipal TUNDURU Region Ruvuma

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name ALPHONCE MATHIAS TILIA PIN ~~[illegible]~~ 0102665 Phone 0622151058

Address P.O.BOX 65149 DSM Email alphoncetilia@gmail.com

A.3. REASON(s) FOR CHANGE

Change of Residence area due to work

Time frame of notification: (As per Contract) 2 Months Signature [signature] Date 17/8/25

A.4. OWNER'S DETAILS

Full Name JOHN JOHN MSWACHI Phone Number 0627250638

Remarks ....

Signature [signature] Date 17-03-2025

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.