

NANA MAKAYA  
Owner  
Nebi Pharmacy  
Ukwamani Kawe  
Kinondoni, Dar es Salaam  
Tanzania

0744210962

06, November 2025



The Registrar  
Pharmacy Council of Tanzania  
P.O. Box 1277,  
Dodoma, Tanzania

**RE: Notification of Temporary Closure of Nebi Pharmacy**

Dear Sir,

I hope this letter finds you well. I am writing to formally notify the Pharmacy Council of Tanzania regarding the temporary closure of **Nebi Pharmacy**, located at Ukwamani Kawe, Kinondoni, Dar es Salaam.

Due to ongoing business restructuring, the pharmacy will be closed from **10th November 2025** to **1st February 2026**. During this period, we will be making significant improvements to the pharmacy's operations and services.

We kindly request your understanding and support during this temporary closure. Should you require any further information or documentation, please do not hesitate to contact us.

Thank you for your attention to this matter.

Yours sincerely,

Nana Makaya  
Owner  
Nebi Pharmacy  
0744210962



THE UNITED REPUBLIC OF TANZANIA

PCF. 17



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..... MEBI PHARMACY..... Facility Identification Number (FIN)..... 0103037  
Physical address:  
Street..... WAZIRI..... Ward..... KKWE..... District/Municipal..... KINNDANI..... Region..... DAR ES SALAM

A.2. DETAILS OF SUPERINTENDENT/OTHER PHARMACEUTICAL PERSONNEL

Full Name..... MUSA ANXITIKI MWAIBAGE..... PIN 0193433..... Phone..... 0768466883  
Address..... Buji Kinndani..... Email..... mwaibagemwa@gmail.com

A.3. REASON(S) FOR CHANGE

Business restructuring

Time frame of notification: (As per Contract)..... NA..... Signature..... [Signature]..... Date..... 10/11/2025

A.4. OWNER'S DETAILS

Full Name..... NANA MAKAYA..... Phone Number..... 0744210962  
Remarks.....  
Signature..... [Signature]..... Date..... 10/11/2025

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.