South African Pharmacy Council
591 Belvedere Street, Arcadia, Pretoria, 0083; Private Bag X40040, Arcadia, 0007;
Tel: 0861 7272 00; E-mail: customercare@sapc.za.org; Website: www.sapc.za.org

Form is valid for **2025** only

APPLICATION FOR EXTENSION OF ACCREDITATION/APPROVAL AS PROVIDER OF PHARMACIST'S ASSISTANTS PROGRAMMES IN TERMS OF THE PHARMACY ACT 53 OF 1974

Please print and use black ink to complete

SECTION A: PROVIDER PARTICULARS

Provider Name			
SAPC Registration Number	R		
Postal Address			
		Postal Code	
Physical Address			
		Postal Code	
Courier Address			
		Postal Code	
Full names of Responsible Person			
Identity/Passport Number			
Telephone Number			
Cell phone number			
Fax Number			
E-mail Address			

SECTION B: PLEASE TICK COURSE(S) REQUIRING EXTENSION

National Certificate: Pharmacist's Assistance (Community) **R2,754.00**		Further Education and Training Certificate: Pharmacist's Assistance (Community) **R2,754.00**	
National Certificate: Pharmacist's Assistance (Institutional) **R2,754.00**		Further Education and Training Certificate: Pharmacist's Assistance (Institutional) **R2,754.00**	
National Certificate: Pharmacist's Assistance (Wholesale) **R2,754.00**		Further Education and Training Certificate: Pharmacist's Assistance (Wholesale) **R2,754.00**	

ALL CORRESPONDENCE TO BE ADDRESSED TO THE REGISTRAR

National Certificate: Pharmacist's Assistance (Manufacturing) **R2,754.00**		Further Education and Training Certificate: Pharmacist's Assistance (Manufacturing) **R2,754.00**	

Please print and use black ink to complete

SECTION C: APPLICABLE FEES AND SUPPORTING DOCUMENTS	**MARK WITH X**
Proof of payment must be submitted in support of this application:	
1. Fee for extension of provider accreditation/approval **(R2,754.00)**	
2. Fee for extension of course accreditation/approval as described in Section B	

SECTION D: DECLARATION BY THE APPLICANT

I, hereby, declare that our provider and course(s) accreditation/approval conditions as a determined by Council have not changed.

Note: In the event of change of ownership and/or delivery of the course, the provider must submit completed forms for accreditation/approval as the provider and for the course(s).

SIGNATURE:					
NAME:					
DESIGNATION:					
DATE:	DD	-	MM	-	YYYY

SECTION E: DECLARATION BY COMMISSIONER OF OATHS

SIGNED and SWORN at _____ on this _____ day of_____ in the year _____, the deponent(applicant) having acknowledged that he/she knows and understands the contents of this declaration

SIGNATURE OF COMMISSIONER OF OATHS :

DATE: DD - MM - YYYY

STAMP

Full name, capacity, address and contact details of Commissioner of Oaths

ONLY ORIGINAL DOCUMENTATION OR CERTIFIED COPIES WHERE APPLICABLE WILL BE ACCEPTED BY THE SOUTH AFRICAN PHARMACY COUNCIL