PRACTICE CODE NUMBERING SYSTEM

BOARD OF HEALTHCARE FUNDERS NPC
Company Registration No. 2001/003387/08

REPLACEMENT RESPONSIBLE PHARMACIST UPDATE FORM

Please Note

1. The completed update form can be sent to pcns_admin@bhfglobal.com
2. Please be advised that as part of the application process PCNS is required to verify the state employ of each Responsible Pharmacist (RP) linked to all Pharmacy application received through the DPSA search (http://www.dpsa.gov.za/psearch/). To ascertain if your RP may be employed by the state, please utilise this link and enter their ID number for results. In order for your application form to be processed timeously please ensure that the necessary approvals (RWOPS Certificate/Resignation letter/Sessional work confirmation /Work Contract) have been submitted for the RP should they be employed by the state together with your application form. Please also supply the contact details of the persons responsible to confirm the approval/resignation.

Required Documents

- Certified copy of ID for the Responsible Pharmacist.
- Certified copy of the passport and proof of permanent residence, where the applicant is not a South African citizen.
- Certified copy of Registration Certificate of the recording of the Responsible Pharmacist.
- Copy of Certificate: Approval of other Remunerative Work, confirming that your Responsible Pharmacist has the necessary permission to practice outside of the conditions of their employment with the state (where applicable)
- Copy of proof from the Pharmacy Council of South Africa that the subscription fee for the Pharmacy and Responsible Pharmacist has been paid for the current year.

SUPPORTING DOCUMENTATION

This update WILL NOT BE PROCESSED WITHOUT CERTIFIED COPIES OF ORIGINAL DOCUMENTATION by a South African registered Commissioner of Oaths authority. **The commissioner of oaths should be someone who is impartial, unbiased, not related to the Healthcare Service Provider (HSP) and who has no interest in the HSP (such as any immediate family members of the HSP, any employee or employer of the HSP or any colleague of the HSP).** The stamp on the certified document must be dated, include the name of the Commissioner of Oaths and the words COMMISSIONER OF OATHS and valid for a period of (6) months from date of submission. Please note that the BHF policy requires that in order to obtain a practice number, an applicant health care professional must be registered by a regulatory body or a licencing authority in terms of South African Law, as this is a requirement of the Medical Schemes Act (Act. No 131 of 1998).

Lower Ground Floor, South Tower
1Sixty Jan Smuts, Rosebank, 2196

P O Box 2863, Saxonwold, 2132
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PC NS
PRACTICE CODE NUMBERING SYSTEM

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REPLACEMENTRESPONSIBLE PHARMACIST UPDATE FORM

Please complete the form in BLOCK letters only OR/ type to complete. Unclear handwriting may delay in the processing of your application for a PCN and lead to errors in the information captured

RESPONSIBLE PHARMACIST

Title _____ Initials _____ First Names _____ Surname _____

ID Number _____ Council Number _____

Government employee (Yes) or (No) If yes, please provide Certificate: Approval of their Remunerative Work

CONTACT DETAILS FOR PERSON RESPONSIBLE TO CONFIRM THE RESPONSIBLE PHARMACIST's RWOPS APPROVAL

Name and Surname _____ Designation _____

Telephone Number _____ E-mail address _____

NB: Please be advised that due to the external validation process with your employer for your RWOP, the issuing of your practice number will be delayed.

PHARMACY DETAILS

Pharmacy Practice Number _____

Practice Postal Address _____

_____

Suburb _____

Town _____

Code _____ Province _____

Telephone Number (_____) _____
(If no telephone number is provided your cell phone number will be captured as the main telephone number on the system as this is a mandatory field)

Practice Physical Address _____

_____

Suburb _____

Town _____

Code _____ Province _____

Cell Number (_____) _____

Email Address _____

I, the undersigned, hereby declare that this above information is valid as on the date of signature hereof.

_____ _____

SIGNATURE OF PHARMACY OWNER **DATE**

_____

PHARMACY OWNER's FULL NAME AND SURNAME

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