Medicines Control Authority of Zimbabwe

LEF 25

LICENSING AND ENFORCEMENT DIVISION

CONFIRMATION OF SUPERVISION - WHOLESALE PREMISES

NAME OF PERMIT HOLDER ……

TRADING NAME ……

PHYSICAL ADDRESS …….

…….

…….

NORMAL TRADING HOURS …….

I ……state that I will supervise the
(First Name(s) (Surname)

above premises for the purpose of section 17 (1) (b) (ii) of the Medicines and Allied Substances Control (General) Regulations, 1991 (as amended). I acknowledge that I shall be held accountable for the activities carried out at the above premises in terms the Medicines and Allied Substances Control Act [Chapter 15:03] and the Regulations. I also state that that I do not supervise any other premises licensed under the Act. In the event of my leaving the position of supervising **Pharmacist/Pharmacy Technician** I will notify the Medicines Control Authority of Zimbabwe of this fact within 24 hours.

Current Persons License No……..
(As issued by MCAZ)

Qualifications ……Pharmacist/Pharmacy Technician

Current Pharmacist Council Practicing Certificate No……

Residential Address……..

Mobile Number……

Signature ……. Date ……