



LICENSING AND ENFORCEMENT DIVISION

CONFIRMATION OF SUPERVISION - LICENSED PREMISES

NAME OF LICENCE HOLDER:

TRADING NAME:

PHYSICAL ADDRESS:

.....

.....

TYPE OF BUSINESS:

(Hospital or Retail Pharmacy)

NORMAL HOURS OF TRADING:

Istate that I will provide

(First Name(s))

(Surname)

Continuous personal supervision of the above mentioned premises for the purposes of Section 55 1 (b) of the Medicines and Allied Substances Control Act [Chapter 15:03] (hereinafter called "the Act"). I acknowledge that I shall be held accountable for the activities carried out at the above mentioned premises in terms of the Act. I also state that I do not supervise any other premises licensed under the Act.

I further state that whilst I am supervising the above mentioned premises, I shall remain resident in Zimbabwe.

In the event of termination of this position of supervising pharmacist I will notify the Medicines Control Authority of Zimbabwe in writing of this fact within twenty-four (24) hours.

Current Persons License No.

(As issued by MCAZ)

Current Pharmacist Council Practising Certificate No.

Residential Address

Mobile Number.....

Signature Date