

DEPARTMENT OF HEALTH

APPLICATION FOR A PERMIT IN TERMS OF SECTION 22A(12) OF THE
MEDICINES AND RELATED SUBSTANCES CONTROL ACT, 1965 (ACT 101 OF
1965)

A. GENERAL INFORMATION

1. Name of Institution/Organisation/Person

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2. Postal Address:

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.....

.....Postal Code:.....

3. Address where service will be rendered:

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Postal Code:Tel Code:..... No:.....

4. Short description of type of organisation/ business:

.....

.....

5. Describe the type of service which will be rendered:

.....

.....

6. Why is the service essential?

.....

.....

7. Who previously rendered the service:

8.2 Name of Medical Aid Schemes/Auxiliary Scheme to which employees/patients belong:

8.3 Number of employees/patients who do not belong to a Medical Aid Scheme:

.....

[illegible]

9.3 CLINICS	DISTANCE FROM INSTITUTION	ACCESSIBILITY
9.4 HOSPITALS	DISTANCE FROM INSTITUTION	ACCESSIBILITY

9.5 Supply detailed reasons why aforementioned services are not sufficient (attach annexure if necessary):

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10. Supply geographical boundaries in which services to be rendered are contemplated:

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10.1 Population of area in which services are envisaged:

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11. Indicate which medicines are required. Approved names only and indicate dosage form. (Attach as annexure)

.....

12. From which supplier(s) will medicines be purchased?

.....

13. Will the Regulations of the Medicines and Related Substances Act, 1965 (Act 101 of 1965) be complied with in respect of the following:

Record keeping

Labeling

14. Describe the control measures which will be applied to ensure that expired medicines will not be issued:

.....

15. **Supply a floor plan of all facilities and describe the:**

- purpose of areas
- venue where medicines will be manipulated and stored with specific reference to:

(a) Locking facilities

(b) Protection against

(i) Light/sun

(ii) Humidity

(iii) Heat - temperature control/refrigeration facilities

(Attach as annexure)

16. Indicate procedures which must be followed during dispensing with special reference to controlling measures in respect of:

- identification of medicines; confirmation that the correct medicines are supplied;
- quantity; confirmation that the correct quantity is supplied;
- indications; information that the correct directions for use are indicated in a legible manner on the label and by whom;
- by whom various functions will be undertaken.

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17. Give a description of the types of packing materials which will be used to ensure the stability of the medicines **AFTER** dispensing:

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18. Describe the process of patient counseling in respect of directions for use, side-effects, contra-indications and special precautionary measures:

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.....

.....

19. Which cleansing procedures are used in respect of:

- Counting apparatus:
- Venue (floor walls etc.)
- Work Surface

B COMPLETE ONLY SECTIONS APPLICABLE TO YOU:

1. NURSING PRACTICE:

1.1 Name of nurse in charge:

1.2 Qualifications Registration Number:

(a)

(b)

(c)

(d)

(e)

(f)

1.3 A certified copy of qualification and registration for the current year with the Nursing Council of South Africa must be attached.

2. ORGANISATIONS (OCCUPATIONAL HEALTH CLINICS)

2.1 Name of Medical Practitioner in charge:

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2.2 Is the Medical Practitioner full time / part time. (Furnish full particulars and mention service hours at the clinic.)

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2.3 Name of Nurse in charge:

2.4 Qualifications Registration Number:

(a)

(b)

(c)

(d)

- 2.5 A certified copy of qualification and registration for the current year with the Nursing Council of South Africa must be attached.
- 2.6 Indicate who will be in charge and in possession of the key of the medicine store/cupboard.
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- 2.7 What is your budget/turnover for medicines: R.....
- 2.8 What procedure is adopted for the repeat of prescription medicines?
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IT IS HEREBY CERTIFIED THAT THE ABOVE INFORMATION IS ACCURATE AND
CORRECT TO THE BEST OF MY KNOWLEDGE

4. SIGNATURE OF:

.....
APPLICANT

.....
DATE

.....
HEAD OF ORGANISATION
(Occupational Health Clinic)

.....
DATE

.....
MEDICAL PRACTITIONER

.....
DATE

.....
NURSE

.....
DATE