

1



Director-General Department of Health Private Bag X828 Pretoria 0001	Director -General Department of Health Hallmark Building 231 Proes Street Pretoria 0002
--	--

DEPARTMENT OF HEALTH

APPLICATION FOR A LICENCE FOR YELLOW FEVER VACCINATION

A. GENERAL INFORMATION

1. Name of Manager of Designated Vaccination Centre:
.....

2. Short description of type of service to be rendered:
.....
.....

3. Postal Address:
.....
.....
.....Postal Code:.....

4. Physical address of premises:
.....
.....

Postal Code:

Tel Code:.....Number:.....

Cellular Number:

Facsimile Number:

E- mail address:

5. Qualifications:.....

6. Registration Number with Statutory Council:

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

8 Who is your supplier of Medicines?
.....
.....

9. Describe the control measures, which will be applied to ensure that the cold change is maintained:
.....
.....
.....
.....

10. What reference source for information given to travellers is available:
.....
.....

11. What is your intended target market?

General Travelling Public	<input type="checkbox"/>	Corporate Travellers	<input type="checkbox"/>
In-bound Tourists	<input type="checkbox"/>	Refugee and Migrant population	<input type="checkbox"/>
Military Institution			

B. PROFESSIONAL STAFF

1.1 Name of **Medical Practitioner** in charge:

1.2 Registration Number with Statutory Council:

1.3 Qualifications:

.....
.....

1.4 Has a course in **Travel Medicine and Tropical Diseases** or any other similar course approved by a health statutory council been successfully completed?

..... (**Attach certified proof of qualification**)

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

.....
.....

1.6 Name of the **Nurse** in Charge:

1.7 Registration Number SANC:

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

1.8 Has a **course in Travel Medicine and Tropical Diseases** or any other similar course approved by a health statutory council been successfully completed?

..... (**Attach certified proof of qualification**)

1.9 Qualifications:

- a).....b).....
- c).....d).....
- e).....f).....

*SECTION C: PARTICULARS OF THE PREMISES		
I, the above applicant declare that:		
1.The size of the dispensary is		m ²
2. Key, key card or other device or the combination of any device, which allows access to the dispensary is kept on the person of the authorized prescriber.	Yes	No
3. Only the authorized prescriber has keys to the pharmacy area where schedule 1 – 6 items are kept.	Yes	No
4. There is sufficient security to prevent unauthorised access to medicines.	Yes	No
5. The pharmacy will be suitably located in the practice.	Yes	No
7. There is/ will be a separate facility for washing hands	Yes	No
8. There is/will be a separate facility for cleaning equipment.	Yes	No
9. The premises will be kept clean, orderly and tidy.	Yes	No
10. The floor surface will be of impermeable material.	Yes	No
11. All working surfaces will be finished with a smooth impermeable and washable material	Yes	No
12. All countertops and shelves will be finished with a smooth, impermeable and washable material which is easy to keep clean	Yes	No
13. Walls are finished with a smooth, impermeable and washable material, which is easy to keep clean	Yes	No
14. There will be sufficient and adequate lighting.	Yes	No
15. There is an air conditioner in the dispensary, which is in good working condition.	Yes	No
16. The temperature in the dispensary will be below 25 °C.	Yes	No
17. There is at least one fire extinguisher or fire hose in the pharmacy.	Yes	No
18. The receiving area for deliveries will be clearly defined and separated from the rest of the consulting room	Yes	No
19. A fridge for heat sensitive pharmaceuticals and vaccines will be available.	Yes	No
20. No bulk stock	Yes	No

D. SUPPLY A SHORT MOTIVATION WHY A LICENCE IS NEEDED:

.....
.....
.....
.....
.....
.....
.....
.....

E. IT IS HEREBY CERTIFIED THAT THE ABOVE INFORMATION IS ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE OF:

.....
**MANAGER OF DESIGNATED
VACCINATION CENTRE**

.....
DATE

.....
MEDICAL PRACTITIONER

.....
DATE

.....
NURSE

.....
DATE

F: 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: _____	STAMP
	Full name, capacity, address and contact details of Commissioner of Oaths