



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
AFFORDABLE MEDICINES DIRECTORATE: LICENSING UNIT
Dr AB Xuma Building, 1112 Voortrekker Road, Pretoria Townlands 351-JR, Pretoria, 0187

RETURN FORMS TO:
Email: yellowfeverlicenses@health.gov.za, Tel: (012)395 8315/8212

**APPLICATION FOR A LICENCE TO OBTAIN AND ADMINISTER YELLOW FEVER VACCINE, ISSUED
IN TERMS OF THE INTERNATIONAL HEALTH REGULATIONS ACT, 1974
(ACT NO. 28 OF 1974)**

I: GENERAL INFORMATION:

NOTE: Applications are processed within 90 days of receipt of all required documents.

- Chapter V of the Supplementary Regulations made under the International Health Regulations Act, 1974 (Act No. 28 of 1974) states that no person may administer yellow fever vaccine unless he or she is a licence holder. Applicants for Yellow Fever Licences may be medical practitioners, nurses or pharmacists.
- Yellow Fever Licence applications are made to the Director-General: Health (DG), who may issue or refuse such licence on such conditions as he or she may deem fit.
- A non-refundable application fee of R450 and a non-refundable annual fee of R100 is payable to the Department on application into the following account:

Bank	:	ABSA
Account Holder	:	National Department of Health
Branch	:	632005
Account No.	:	405 364 3510
Account type	:	Cheque account
Beneficiary Ref.	:	Statutory Council Registration Number ONLY

(Note: Where the registration number is less than 8 numbers – please add zero’s at the end to make up 8 numbers)
- If the Director-General refuses to issue a licence, the Director-General shall inform the applicant in writing thereof, providing reasons for the issuing the licence.
- The Yellow Fever Licence is valid for a period of five years, and such licence is not transferable to any other person. An application for renewal of the licence may be submitted to the Director-General 90 days before the expiry of the licence.
- Completed application forms and supporting documents must be emailed to: yellowfeverlicenses@health.gov.za. The email **subject line should be Yellow Fever New/Renewal – Dr/Sr Initials & Surname**
- The following documents must be submitted with the application form:
 - Certified copy of Identity Document
 - Certified copy of a certificate confirming completion of an approved course in Travel Medicine and Tropical Diseases
 - Proof of current registration with the relevant Statutory Council (annual fee payment)
 - Proof of payment of the non-refundable application fee of R450 and annual fee of R100
 - Nurses Only:** Authorisation in terms of Section 56(6) of the Nursing Act, 2005 (Act No. 33 of 2005)
- Incomplete applications will not be processed.**
- Application outcomes will be communicated to the applicant via email, using the email address completed on the form.



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II: COLLECTION ADDRESS

National Department of Health
Dr AB Xuma Building
Affordable Medicines: Licensing Unit
1112 Voortrekker Road
Pretoria Townlands 351-JR
Pretoria
0187

III: ENQUIRIES

Queries in relation to Yellow Fever Licence applications may be emailed to:

Email: yellowfeverlicenses@health.gov.za,

Please ensure to have the **email subject** as:

Yellow Fever - Initials & Surname- Statutory registration number, Query

Tel: (012)395 8315/8212

III: CHECKLIST OF DOCUMENTS TO BE ATTACHED

Document	Tick
1. Certified copy of identity document	
2. Proof of registration with Statutory Council	
3. Proof of payment of Statutory Council annual fees	
4. Certified copy of Travel Medicine Certificate	
5. Proof of payment of application fee of R450 and licence annual fee of R100	
6. Nurses only: Authorisation in terms of Section 56(6) of the Nursing Act, 2005 (Act No. 33 of 2005)	
7. HPCSA registration copy of doctor authorising Section 56(6)	



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APPLICATION TYPE (tick applicable)	<input type="checkbox"/> NEW	<input type="checkbox"/> RENEWAL	<input type="checkbox"/> Licence no. (renewals only)	
SECTION A: APPLICANT INFORMATION				
Title			Initials	
Surname				
Full names				
Identity Number				
Statutory Council Name				
Statutory Council Registration Number				
Home Telephone Number			-	-
Cell Number			-	-
E-mail address				
SECTION B: RESIDENTIAL ADDRESS DETAILS				
Street Address				
Code			Province	
Postal Address				
Postal Code				
SECTION C: QUALIFICATIONS [ATTACH CERTIFICATE COPIE(S)]				
Qualification				
Institution				
Qualification				
Institution				
SECTION D: TRAVEL MEDICINE AND TROPICAL DISEASES COURSE (ATTACH CERTIFICATE COPY)				
Name of Provider				
Course Name				
Date of Completion				
SECTION E: DISPENSING COURSE (Where applicable)				
Name of SAPC Accredited Provider				
Course Name				
Date of Completion				Licence Number (if applicable)



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SECTION F: VACCINATION CENTRE DETAILS

Vaccination Centre Name												
Street Address of Premises												
Code										Province		
Postal Address of Premises												
Postal Code												
E-mail address												
Business Phone Number										-		-

SECTION G: VACCINATION CENTRE MANAGER DETAILS

Title										Initials				
Surname														
Full names														
Identity Number														
Statutory Council Name														
Statutory Council Registration Number														

SECTION H: MEDICAL PRACTITIONER CHARGE OF VACCINATION CENTRE (If different to applicant)*

Title										Initials					
Surname															
Full names															
Identity Number															
Statutory Council Name															
Statutory Council Registration Number															
Travel Medicine Course Provider															
Course Name															
Date of Completion											Licence Number				
Dispensing Course Provider (where applicable)															
Course Name															
Date of Completion											Licence Number				



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SECTION I: SERVICES AND ACTIVITIES OF VACCINATION CENTRE

1. Service Description (Briefly describe services to be rendered below)

2. Contemplated geographical boundaries in which services are to be rendered

3. Intended target market (tick below)

General travelling public	<input type="checkbox"/>	Corporate travellers	<input type="checkbox"/>
Inbound tourists	<input type="checkbox"/>	Refugee and migrant population	<input type="checkbox"/>
Military institution	<input type="checkbox"/>	Other (specify) _____	

4. Motivation for the need for a Yellow Fever Licence

5. Supplier(s) of medicines

6. Control measures to ensure that cold chain is maintained

7. What reference resources are given to travelers for information



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SECTION J: INFORMATION ON THE PREMISES

I, _____ (full names) the above applicant declare that:

1. The size of the dispensary / medicine room is		m ²
2. Key, key card or other device or the combination of any device, which allows access to the dispensary / medicine room, is kept on the person of the authorised prescriber.	Yes	No
3. Only the authorised prescriber has keys to the 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 dispensary / medicine room will be suitably located in the practice.	Yes	No
6. There is / will be a separate facility for washing hands.	Yes	No
7. There is / will be a separate facility for cleaning equipment.	Yes	No
8. The premises will be kept clean, orderly and tidy.	Yes	No
9. The floor surface will be of impermeable material	Yes	No
10. All walls, working surfaces, countertops, cupboards and shelves will be finished with a smooth impermeable and washable material	Yes	No
11. There will be sufficient and adequate lighting.	Yes	No
12. There is an air-conditioner in the dispensary / medicine room, that is in good working condition.	Yes	No
13. The temperature in the dispensary will be below 25°C	Yes	No
14. There is at least one fire extinguisher or fire hose.	Yes	No
15. The receiving area for deliveries will be clearly defined and effectively separated from the dispensary / medicine room.	Yes	No
16. A fridge for heat sensitive pharmaceuticals and vaccines will be available.	Yes	No
17. There is/will be no bulk stock will be kept at the premises	Yes	No



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NURSES ONLY
SECTION K: AUTHORITY UNDER SECTION 56(6) OF THE NURSING ACT (ACT 53 OF 2005)

1. Name of Nurse

2. ID Number

3. SANC Number

4. Name of Clinic/Facility

You are hereby authorised to diagnose, prescribe and dispense medicines for the conditions listed in the standing orders of the clinic, and according to the treatment protocols listed below, and subject to limitations imposed by the Regulations to Section 38A of the Nursing Act.

You are to maintain legible, comprehensive clinical notes in the patient file and to complete the drug register required under the licence issued in terms of Section 22C(1)(a) of the Medicines and Related Substances Act (Act 101 of 1965, as amended).

Name of Medical Practitioner in charge

HPCSA Registration Number (*attach copy*)

Telephone Number

Signed at _____ on _____ day of _____ 20__

Signature _____ Qualification(s) _____

Note:

Attach proof of employment on the official company letterhead, signed by the authorised person.

Area of Specialisation	Tick below	Proof Attached (YES or NO)	Protocol Competencies	Tick below	Proof Attached (YES or NO)
Primary Health Care			Sexually Transmitted Infections (STI)		
Occupational Health			Expanded Programme of Immunisation (EPI)		
Travel Medicines			Tuberculosis (TB)		
Diabetes			Other (specify)		
Hypertension			Other (specify)		



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SECTION L: APPLICANT DECLARATIONS AND UNDERTAKINGS

I _____ (full name) hereby state under oath, the following:

1. The information furnished herewith is true and all supporting documents are valid;
2. I have not been convicted of an offence which is of such a nature that renders me unsuitable to perform any function or provide any service authorised by any licence/permit issued;
3. I declare that I am registered with, and in good standing with my statutory council;
4. I undertake to inform the Director General of any changes pertaining to any licence/permit issued, including but not limited to changes in name, physical address and contact details;
5. I undertake to comply with all applicable laws, regulations, rules and professional obligations;
6. I undertake to keep abreast and abide by the guidelines of the WHO International Travel and Health: Vaccination Requirements and Health Advice for the vaccination against yellow fever, and when advising patients on other travel-related health risks;
7. I undertake to have a system in place to keep abreast of relevant travel medicine information and outbreaks of diseases worldwide;
8. I undertake to inform the Director General of the loss of, or damage to any licence/permit issued;
9. Nurses only: I undertake to inform the Director General of any changes relating to the authorisation granted to me in terms of Section 56(6) of the Nursing Act 33 of 2005;
10. I undertake to have a system in place to keep abreast of relevant travel medicine information and outbreaks of diseases worldwide;
11. I undertake to display any licence/permit issued conspicuously at the premises for which I have applied;
12. I am aware that any licence issued shall be valid for a period of five (5) years only;
13. I undertake to pay annual fees applicable to any licence/permit issued;
14. I undertake not to provide services as authorised by the yellow fever licence issued to me after such licence has expired;
15. I am aware that the yellow fever licence issued to me is not transferable to any other person/s.
16. I undertake to familiarise myself with the Regulations made under the International Health Regulations Act, 1974 (Act 28 of 1974) which pertains to yellow fever;
17. I undertake to familiarise myself with conditions under which the Director General may revoke or suspend a licence as stipulated in the International Health Regulations Act, 1974 (Act 28 of 1974);
18. I undertake to maintain a register for administration of Yellow Fever Vaccines, and will submit this information to the Department of Health on or before 15 January annually;
19. I hereby give consent for an inspection of the premises in terms of the applicable legislation either before a licence/permit is issued, while any licence/permit issued is valid or after it has been cancelled / withdrawn.

Signature: _____

Date: _____

SECTION M: APPLICANT DECLARATIONS AND UNDERTAKINGS

The abovementioned was SIGNED and SWORN before me at _____ (place)

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: _____

Capacity: _____ Contact details: _____

*Stamp
(Compulsory)*