APPLICATION FORM FOR APPROVAL OF PHARMACY/ CHEMIST / DRUGGIST SHOPS / MEDICAL STORE AS TRAINING CENTRE FOR D.PHARM STUDENTS

1. Name of Pharmacy/ Chemist/Druggist Shop: _____
Medical store

_____

Govt._____ Pvt._____

(Please tick the relevant)

2. Complete postal address : _____

_____

_____Pin code_____

3. **Details of Owner** : _____

a. Name of the Owner : _____

b. Complete Residential Address : _____

_____Pin code_____

c. Telephone No. : STD Code _____ Landline_____

d. Mobile No. : _____

e. E.Mail : _____

4. Whether the Pharmacy /Chemist/Druggist Shops/ Medical Store is approved under Drug & Cosmetics Rules, 1945 framed under Drug & Cosmetics Rules, 1940 (if yes, attach the copy of license with date of validity) : Yes No

(Please tick the relevant)

Date of Validity : _____
of license

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5. Details of Registered Pharmacist working (in Nos.)
(attach the copy of Qualification Certificate and Pharmacist Registration Certificate of each Pharmacist)

Name	Gender (M/F)	Mobile No.	E-Mail	Qualification (attach a copy of qualification certificate)	Registration No. with name of State Pharmacy Council (attach a copy of valid registration certificate)	Registration valid upto	Signature of Pharmacist

6. Whether the name of Owner is displayed on Pharmacy: Yes No

Declaration:

1. I hereby declare that all statements made in the application are true, complete and correct to the best of my knowledge and belief.
2. I will impart training to only students of those Institutions/Colleges/University institutions are approved under section 12 of the Pharmacy Act, 1948.
3. It is also certified that during the course of the practical training, the trainee will be given an exposure to -
   i. Working knowledge of keeping of records required by various Acts concerning the profession of Pharmacy, and

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ii. Practical experience in -

a. the manipulation of pharmaceutical appartus in common use.
b. the reading, translation and copying of prescription including checking of doses;
c. the dispensing of prescription illustrating the commoner methods of administering medicaments; and
d. the storage of drugs and medical preparations.

4. I understand that in the event of any information being found untrue / false / incorrect this application will be cancelled/ rejected, without assigning any reasons thereof.

Date : _____

Place : _____

(Signature of Owner/Applicant)

Name of Owner:

_____

Mobile No:

_____

Forwarded by State Pharmacy Council to PCI (Office use only)

Name of the Registrar	
Name and address of State Pharmacy Council	

Date:_____ Signature :

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