CHECK LIST NO.II

FOR OBTAINING RETAIL DRUGS LICENCES

Sl. No.	Procedure/Detailed Papers to be enclosed (Duly attested wherever applicable)	For use by the applicant	For Office use.	
*	Typed application in standard size paper requesting for the application form etc. to be addressed to the respective Inspector of Drugs at the District Head Quarter and to the Senior Inspector of Drugs for applicants in East Khasi Hills, District.			
1	Prescribed Application Form.			
2	Requisite fees Payment through Treasury Challan (non-refundable)			
3	Recent passport size photo of the applicant - 6 Nos			
4	Educational Qualification Certificate of the applicant.			
5	Age Certificate of the applicant.			
6	Specimen Signature of the Applicant			
7	No Objection Certificate from Municipal Board/ Local Durbar / Cantonment Board.			
8	(a) Scheduled Tribe Certificate for Khasi/Jaintia/Garo OR (b) T.N.T. Certificate for other tha			
9	P.R.C./EPIC/Bank Account/PAN Card/Current Electricity Bill/Current Telephone Bill / Driving Licence/Income Tax & Sale Tax Clearance Certificate/Passport.			
10	Documents pertaining to the legal tenancy of the premises (Own/Rental).			
11	Key and Site Plan of the premises showing the area in square metres (Min. 10 Sq.m Carpet area and 2.5m height).			
12	Purchase Invoice / Documents of cold storage facility.			
13	Duly filled in Undertaking I in Original (attach supporting documents).			
14	Duly filled in Undertaking II in Original (attach supporting documents).			
15	Provisional List of staff with complete biodata, (attach supporting documents, Qualification, Age and 1(one) Photo each.			
16	Recent passport size photos of the Registered Pharmacists - 6 Nos.			
17	Educational Qualification Certificate of the Registered Pharmacists.			
18	Age Certificate of the Registered Pharmacist.			
19	Specimen Signature of the Registered Pharmacist. .			
20	Uptodate Registration Certificate of the Pharmacist with Meghalaya Pharmacy Council			
21	(a) Partnership Deed/Agreement for Partnership Firm/Ltd. Company OR (b) Declaration of Sole proprietorship.			
22	Complete self addressed stamp envelope (with Pin Code)			
23	This Check List No. II.			
*	The Prescribed application Form alongwith enclosures to be submitted to the respective Inspector of Drugs or Senior Inspector of Drugs within 3 months from the date of issue.			
*	Incomplete form will be summarily rejected.			

FORM-19
[See Rule 59(2)]

Application for grant or renewal of a license to sell, stock or exhibit or offer for sale or distribute drugs other than those specified in Schedule X.

1. I/We _____ of (complete residential address) _____ hereby apply for a license to sell by *Wholesale/*Retail Drugs* specified in Schedules C and C (I) excluding those specified in Schedule X and/or drugs* other than those specified in Schedules C, C(I) and X to the Drugs and Cosmetics Rules, 1945 and *also to operate a pharmacy on the premises situated at (complete address of the premises) _____

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in the name and style of M/s. _____.

2. *The sale and dispensing of drugs will be made under the personal supervision of a qualified person(s) namely :-

Name_____ Qualification _____

Name_____ Qualification _____

3. Categories of drugs to be sold _____

_____

_____

4. Particulars for special storage accommodation _____

_____

5. A fee of rupees Three Thousand Only has been credited to Government under the head of account 0210-Medical & Public Health, 04-Public Health/104-Fees fines etc (a) Drugs License fee, fine etc. General T.V. No. _____ Date _____.

Date _____ Signature _____

[30][FORM 19-C

[See Rule 59(2)]

Application for grant or renewal of a [31][licence to sell, stock, exhibit or offer for sale, or distribute] drugs specified in Schedule X

1 I/We _____ of _____ hereby apply for a licence to sell by *wholesale/retail drugs specified in Schedule X to the Drugs and Cosmetics Rules, 1945. We operate a pharmacy on the premises, situated at .....

2 + The sale and dispensing of drugs will be made under the personal supervision of the qualified persons mentioned below:-

_____ (Name) _____ (Qualification)

_____ (Name) _____ (Qualification)

3. Names of drugs to be sold. _____

4. ++ Particulars of storage accommodation _____

5. A fee of rupees _____ has been credited to Government account under the head of account _____.

Date .....

Signature _____

ADDITIONAL INFORMATION WITH FORM 19/RETENTION APPLICATION.

1. Full name of the Applicant:_____
2. Complete Residential address:_____
3. Educational Qualification:_____
4. Date of Birth:_____
5. Occupation/ Business from the last 3 years:_____
6. Present Occupation:_____
7. Experience in Selling Drugs:_____
8. Any earlier Rejectionof application:_____
9. Any earlier Warning/Suspension/Cancellation/Surrendered of licence:____
10. Full name of the person in-charge of the premises:_____
    (Registered Pharmacist or Regd. Exp. Person or Licensee)
11. The Firm/ Company is: (a) Drugs store (b) Pharmacy
    (c) Distributing Agency (d) Commission agent
    (e) Importer (f) Others
12. Full name of the Partners/ Directors in case of Partnership firm or Co Ltd:
    (Enclose Deed/AgreementEtc)
    (a)_____
    (b)_____
    © _____
13. Has any of the persons engaged here ever convicted and sentenced under any Act of the Country:(If Yes, submit Details of the
    Person)_____
14. Has the applicant ever dealt/ imported spirituous medicinal or toilet preparations manufactured within the state/ other states?_____
    (If so the statement of the name of the manufacturer, such preparations with quantity and dates during the last one year duly signed and dated to be enclosed.)
15. Name of the Manufacturing Company Authorising the Applicant to deal with its products(Appointment Letter (s)
    enclosed):_____
16. Premises:

AreaSq.m	Own/Rental	Working Hours	Weekly holiday	Other goods dealt in

17. Trading Licence valid upto:_____

I certify that all the above information are true and I understand that my application is liable to be rejected if any of the above information is proven to be false.

Date: _____

Signature of the applicant
Ph.No_____

UNDERTAKING – I

I, Mr./Ms._____, do hereby execute the following terms and conditions: -

1. That, I shall appoint Mr./ Miss/ Mrs. _____, the **Registered Pharmacist / Competent Person** as the full time in charge in my proposed Firm.

2. That, in case the appointed In-charge resigns, I do hereby undertake that I shall intimate such resignation to the Licensing Authority immediately.

3. That I shall fill up the vacancy so created by another Registered Pharmacist/ competent Person, within a period of **1(one) month** from the date of such resignation.

4. That, in the event where necessary replacement cannot be made as undertook at sl.no. 3 above, I shall comply to the directions issued by the Licensing Authority without any delay.

5. I undertake that I shall inform the Licensing Authority of any additional authorization from the manufacturer (s) along with the product list(s) at the earliest (FOR WHOLESALES ONLY).

6. That I shall abide by the Rules and Regulations specified in the Drugs and Cosmetic Act 1940 and Rules 1945, the Pharmacy Act 1948 and other related Acts as applicable.

I have submitted this undertaking towards fulfillment statutory requirements of the Drugs & Cosmetics Act and Rules framed thereunder.

Signature:_____

Permanent Address:_____

_____

Phone No. _____

Date: _____

UNDERTAKING – II

I Mr./Ms _____,the

Competent Person / Registered Pharmacist of M/s_____ I am

however to undertake the following terms and conditions :-

1. That I do hereby undertake that I shall render my service as a full timer with the said firm.
2. **That I agreed to serve in the above firm without assigning any reason thereof, for a minimum period of 1(one) year with effect from the date that will appear in the License and to renew before the 31st December every year.**

3. That if, after one year of my service, I desire to resign from the said firm, I shall tender my resignation giving at least three months time to the proprietor of the firm with a copy to the Licensing Authority.
4. That I am also declaring the following information along with supporting documents:-

   a). Qualification:_____

   b). Date of Birth:_____

   c). Registration No. and Validity
   (Meghalaya Pharmacy Council)_____

   (d) Details of work experience :

   i) Name of the firm _____

   ii) Address _____

   iii) Date of joining _____

   iv) Date of leaving _____

   v) Nature of work done _____

   vi) Reason for leaving _____

I certified that the above declaration is true to the best of my knowledge; In case of any false statement being found as stated above, I am liable to any action Government deem fit and proper.

Signature :_____

Permanent Address: _____

_____

Pin _____

Date._____ Phone No. _____

IST OF STAFFS OF M/S. _____ LOCATED AT _____ DRUGS LIC NO. & VALIDITY _____

nstruction - Every particulars in the format should be neatly and correctly furnished and supported with relevant documents.

Sl. No.	Name of Staff	Place of Birth	Date of Birth	Academic Qualification	Date of Joining	Designation	Stamp size photograph	Specimen Signature	For Office use only.
1									
2									
3									
4									
5									

Certified that the above particulars are true. If any statement made thereof is found to be false, I shall liable to any action as deem fit and proper by the Govt. Further, I / We under take to intimate whenever there is any change in the composition of my/our staff, immediately within one month.

Signature with date of the Proprietor / Partners