DECLARATION FORM

(This must be filled and returned to the Deputy Director Medical, OFFICE OF THE DIRECTORATE OF HEALTH SERVICES, Port Blair along with the application form)

N.B: No column should be left blank or with a dash, if you have no particulars to furnish for any column, NIL 'Does not arise"

1. Name and complete address of the Firm for which application is made :

2. Name and residential address (es) of the Proprietor / all partners / all Directors / Manager. :

3. Applicant's previous occupation :

4. Applicant's present occupation :

5. Applicant's experience, if any in Drugs Trade :

6. Is the application for fresh licence or Renewal :

7. Was there any change in the Proprietorship: Partnership of the concern since the issue of previous licences and if so from what date? (A true copy of the sale deed should be sent)

8. Was there any change in the premises of the concern since the issue of the previous licences and if so, from what date? :

9. Particulars of licences held by the applicant in respect of the premises for which the present application is made :

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10. Addresses of other premises where the drugs are stocked or sold or office is maintained by the applicant. The drugs Licences number, form of licence and Date of issue of each licence pertaining to the above should be stated. :

11. Is the firm or company as :
    a. Restaurant b. Provision stores
    c. Betalnut shop, d. General Merchants
    e. Chemists and Druggists f. Pharmacy (Stores) g. Wholesale dealer h. Imports
    i. Distributing Agency (State the name of the manufacturers for whom you are distributors of agencies) and furnish a true copy of the agreement.

12. Is there a separate cupboard or drawer reserved solely for the storage of schedule x drugs. :

13. a) Nature of the cold storage provided :
    b) Whether it is in working condition

14. If running a pharmacy whether, the requirements of schedule "N" to the Drugs Rules have been provided (list of equipment and books available should be enclosed :

15. Particulars of qualified

Name	**Qualification**	**Reg.No.**

16. Hours of business and working days :

17. Where you ever convicted under the Drug Act or any other Act? :

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18. Was the application ever rejected or licence previously cancelled or suspend or surrendered :

19. Are you the legal tenant :

I declare that the above statements are true; I further declare that I conversant with the provisions of the Drugs Act, 1940 and the Drug Rules 1945 and I will abide by the conditions of the licenses.

Station:

Date: Signature of the Applicant

Declaration of the Pharmacist (s) competent person:

I / We hereby declare that I / We am employed in the above firm as full time qualified person (s) and not employed any where else.

Date: Signature of the qualified Person (s) / Competent Person