

APPLICATION FORM FOR APPROVAL OF TRAINING CENTER

To
The President
Maharashtra State Pharmacy Council
Mumbai

Subject :- Request for approval of our Pharmacy as training center under provision of Pharmacy Practise Regulations 2015.

Sir,

I am/We are proprietor/partners/directors of M/s. _____
a retail/hospital pharmacy situated at _____
_____, we hold licenses in form 20,21 _ _ _ from
Food and Drugs Administration, Maharashtra, we request you to approve our
firm/establishment as a training center to impart practical training to D.Pharm. students as a
part of their pharmacy education and fulfilling the eligibility criteria for their registration as
pharmacist. We are furnishing the following information to assure regarding the good pharmacy
practices at our establishment.

A. Details of Registered pharmacist in service

- 1) No. of Pharmacists appointed _____

- 2) Names of Registered Pharmacist _____

- 3) Details of Registration (enclosed a copy of Registration Certificate and PPP card)
(For every appointed Registered pharmacist only two students will carry out practical
training).

- 4) Whether any of the appointed registered pharmacist has been guilty of professional
misconduct under section 36, if yes, give details _____

B. Validity and details of drug licenses.

(enclose photocopies)

- i) Whether the licenses of firm had ever been suspended or cancelled by Food and Drugs Administration, Maharashtra, for violation of Drugs & Cosmetics Act or other laws like DPCO,DMR,NDPS etc.
- ii) Had the licensee/proprietor/partner/Director had ever been convicted for any offence in past, if yes, give details.
- iii) Is there any pending case/F.I.R. against the proprietor/partner/Director of the firm for any offence in any court/tribunal/administrative authority in India. Yes/No, if yes give details.

C. Details of patient counselling activities or public health awareness activities carried out by firm/establishment (enclose copies of leaflets/posters/pictures/media cutting etc. if any)

I/We assure that all the above information given is true and correct to the best of my/our knowledge, if anything found to be false, I am aware that council reserves the right to revoke the approval of my pharmacy/firm at any time in future without giving any reason or explanation.

Yours faithfully,

Date :

Place :

Name of owner _____
Reg.No.(if applicable) _____
Sign & Stamp of firm