

AFFIDAVIT (By Pharmacist / Competent Person)

I, Mr./Ms. _____ [Name of the Pharmacist], aged about [age] years, S/o or D/o [Father's Name], residing at [Full Residential Address], do hereby solemnly affirm and declare as under:

1. That I am a Registered Pharmacist under the Uttarakhand State Pharmacy Council, holding Registration Certificate No. [Registration Number], dated [Date of Registration], which is valid and subsisting as on date.

2. That I have been appointed as a full-time pharmacist at the premises of M/s [Name of Firm/Medical Store], situated at [Full Address of Store], for supervising and conducting the sale, storage, and dispensing of drugs as per the provisions of the Drugs and Cosmetics Act, 1940 and Rules, 1945.

3. That I am not engaged in any other employment, business, or profession and shall render my services exclusively to the said firm M/s [Name of Firm] during the validity of the drug license.

4. That I shall ensure the sale of all Schedule H, H1, and X drugs strictly against valid prescriptions and maintain proper records/register as prescribed under the law.

5. That I am aware of and shall comply with all the provisions of the Drugs and Cosmetics Act, 1940, Rules, 1945, and any other related laws or directions issued by the Licensing Authority / Drugs Control Department, Uttarakhand.

6. That I shall remain personally responsible for ensuring proper storage, handling, and sale of medicines and for maintaining the statutory records of the said medical store.

7. That the contents of this affidavit are true and correct to the best of my knowledge and belief, and nothing material has been concealed therefrom.

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DEPONENT

(Signature of the Pharmacist)

Name: _____

Pharmacy Registration No.: _____

Address: _____

Mobile No.: _____

Date: _____

Place: _____

VERIFICATION

Verified at [Place] on this [Date] that the contents of this affidavit are true to the best of my knowledge and belief and nothing material has been concealed therefrom.

DEPONENT

AFFIDAVIT OF PROPRIETOR

I, _____, aged about [age] years, _____ S/o or D/o [Father's Name], residing at [Full Residential Address], do hereby solemnly affirm and declare as under:

1. That I am the Proprietor / Partner / Authorized Signatory of the firm named M/s [Name of Firm], having its office/premises situated at [Full address of the premises], which is proposed to be used for selling / stocking / exhibiting for sale / or distributing drugs by retail / wholesale.

2. That the said premises are owned / rented / leased by me/us and will be used solely for the purpose of operating the said medical store.

3. That the premises are equipped with adequate facilities for proper storage of drugs under prescribed conditions as per the Drugs and Cosmetics Act, 1940 and Rules, 1945.

4. That Mr./Ms. [Name of Pharmacist / Competent Person], who holds a valid Registration Certificate No. [Registration Number] issued by the Uttarakhand State Pharmacy Council / other competent authority, has been appointed as the Registered Pharmacist / Competent Person for our firm and shall personally supervise the sale and handling of all drugs as required under law.

5. That I/we undertake to abide by all provisions of the Drugs and Cosmetics Act, 1940, Rules, 1945, and any other instructions or directions issued by the Drug Licensing Authority from time to time.

6. That The premises intended to be used for this purpose (shop) has an area of **feet in length and ----- feet in width**, covering a total area of - **square feet (square meters)**. The premises are well-constructed and equipped with **signboard, counter, racks, and electricity facility**. It also contains a **refrigerator model no. _____** Having a capacity of _____ **liters**, used for the proper storage of temperature-sensitive medicines as per regulatory norms.

The surrounding boundaries of the said premises are as follows:

- **East:**
- **West:**
- **North:**
- **South:**

7. The premises meet all required standards as per the **Drugs and Cosmetics Act, 1940** and **Rules, 1945**. All necessary facilities such as **refrigerator, ventilation, and adequate arrangements for storage of medicines** are available at the said shop.

8. That I/we have never been convicted under the Drugs and Cosmetics Act, 1940 or any other law relating to drugs and have not been involved in any criminal offence.

9. That all information and documents furnished along with this application are true and correct to the best of my knowledge and belief, and nothing has been concealed there from.

10. That I further declare that I intend to obtain a **Retail Drug Licence** for the sale of medicines at the above-mentioned premises. The requisite **application fee of ₹3000/-** has been paid through challan no. _____ dated _____.

11. That my application for the grant of license /retention has never been rejected by the Licensing Authority.

12. That I do hereby solemnly affirm and declare that I do not intend to stock or sell any drug formulation containing narcotic substances, and that no Schedule-X drugs will be stocked or sold without obtaining the due license from the competent authority.

I hereby verify that the contents of the above affidavit are true and correct to the best of my knowledge and belief and that nothing material has been concealed therefrom.

DEPONENT

(Signature of the applicant)

Name: _____

Designation: _____

Address: _____

Date: _____

Place: _____

VERIFICATION

Verified at [Place] on this [Date] that the contents of this affidavit are true to my knowledge and belief, and nothing material has been concealed.

DEPONENT

**APPOINTMENT LETTER OF PHARMACIST / COMPETENT PERSON
(FULL-TIME BASIS)**

File No.:

From:

M/s _____

To,

Mr./Ms. _____

Address: _____

Subject: Appointment of Pharmacist / Competent Person on Full-Time Basis

Dear Sir/Madam,

With reference to our personal discussion regarding the post of Pharmacist/Competent Person, you are hereby appointed as a full-time Pharmacist/Competent Person with our firm on the following terms and conditions:

1. Monthly Salary: ₹ _____
2. Date of Appointment: _____
3. Weekly Holiday(s): _____
4. Lunch Time: _____

Notice of termination: One month either side.

If the above terms and conditions are acceptable to you, please give your consent to join duties with immediate effect.

Yours faithfully,

For M/s _____

(Signature of Proprietor)

Name: _____

Designation: Proprietor

Accepted:

(Signature of Pharmacist / Competent Person)

