GOVERNMENT OF MEGHALAYA
OFFICE OF THE HEALTH AND FAMILY WELFARE

APPLICATION FORM FOR THE GRANT /RENEWAL OF LICENSE TO REPACK FOR SALE OR FOR DISTRIBUTION OF DRUGS OTHER THAN THAT SPECIFIED IN SCHEDULE C, C(1) EXCLUDING THOSE SPECIFIED IN SCHEDULE X

FORM 24 B

(see Rule 69)

*Please specify the purpose of application- **New registration for Grant of license / Renewal of license (Dropdown)**

*Do you hold any previous cancelled license-Yes/No(Dropdown)**(To be activated only if above answer is "New registration for Grant of license"**

*Please specify license no- (To be activated only if above answer is Yes)

*Please select district-**East Khasi hills, West Garo hills, West Jaintia hills, West Khasi hills, East Garo hills, Ri Bhoi district, South Garo hills, South West Garo hills, South West Khasi hills, East Jaintia hills, North Garo hills, Eastern West Khasi hills**

Comment [DM1]: Backend mapping for directing the application form to the concerned inspector of drugs

Input parameters(Mandatory)	Validations
Name of the applicant	Open text
Residence address of the applicant	Open text to be segregated
Mobile number to be registered	Only numbers
Email id to be registered	Alphanumeric
Address of the manufacturing premise	Open text to be segregated
Name of drug/s	10 inputs to be allowed using "+
Please enter details of technical staff employed for manufacturing and testing	Multiple inputs to be allowed using "+
Name	Open text
Qualification	Open text
Experience	Open text
License no	To be activated only for renewal
Expiry date of license	To be activated only for renewal(Calender input)
Plz specify if any additional item is required	Multiple inputs to be allowed using "+"

Plz note-If expiry date has exceeded 6 months from the date of application for renewal, user to get pop up as "**Your license no –( ) is no longer valid**"

Self Declaration-

I declare that the above mentioned drugs are not specified in Schedule C, C1 and excluding those in Schedule X (Check box)

I am ready to abide by the rules and regulation of and to pay necessary fees fixed by the office of health and family welfare and I declare that all information given above is true to my knowledge and belief (check box)

***If declare I have abided by Schedule M*- **GOOD MANUFACTURING PRACTICES AND REQUIREMENTS OF PREMISES, PLANT AND EQUIPMENT FOR PHARMACEUTICALPRODUCTS (check box)**

Comment [DM2]: Schedule M to be made downloadable to user here