

Family Pharmacy Network Application Form

1. Name of the Pharmacy :
2. Address :
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3. City :
4. State : Zip Code:
5. Contact Number :
6. Email Id :
7. Branches (If Any) :
8. Web site (If any) :
9. Type of facility (Retail/Distributor) :
10. Years of Operation :
11. Pharmacist Certificate No : (Provide a copy)
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12. Registration Number :
13. Registration Valid Up to date :
14. Registering Authority :



- 15. Working Days :
- 16. Working hours :
- 17. PAN Number :
- 18. Number of Pharmacists :
- 19. Number of Other staff :
- 20. Medicine rates (Mandatory) : YES**
- 21. Home sample collection : YES / NO
- 22. Home delivery : YES / NO
- If having own delivery team : YES / NO
- 23. Require a web portal : YES / NO
- 24. Contact Person with Number :
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Declaration

I hereby wish to inform you that the information provided towards empanelment is true to the best of my knowledge. We understand the details and are interested in empaneling with Family pharmacy Network.

For Pharmacy Name of the Signing Authority with Designation :

Signature with Date :

