National Medicines Regulatory Authority

120, Norris Canal Road, Colombo 10, Sri Lanka.
Telephone: +94 112 698 896/7 Fax: +94 112 689 704 Email: info@nmra.gov.lk
Website: www.nmra.gov.lk

Declaration of the Responsible Pharmacist

I declare that I am the responsible pharmacist of .....
.....*(Name of the wholesale/ retail pharmacy)* on the premises situated at
.....
(Address of the wholesale/ retail pharmacy) and that the information provided in this application for registration is complete, true, and accurate. I hereby undertake to notify NMRA if any change in circumstances made in it. I declare that the service model from the wholesale/ retail pharmacy will include the following:

1. **The sale of Medicines**
2. **The sale of Veterinary Medicines**
3. **The sale of Medical Devices**
4. **The sale of Borderline Products**

(Obliterate the irrelevant sections)

I confirm that I have read and undertake to meet the NMRA guidelines & regulations for wholesale/ retail pharmacy in respect of these premises *(The NMRA guidelines & regulations for registered pharmacies published by NMRA are available at www.nmra.gov.lk)*.

I understand that I have a duty to inform NMRA of any change in the service model of any of my wholesale/ retail pharmacy which will affect the registration status of the wholesale/ retail pharmacy wholesale for which I am responsible.

I understand that if it is found that the information given in this application for registration is false or misleading, this may be treated as misconduct, which may result in removal from the registration of the wholesale/ retail pharmacy.

I understand that I have a duty to inform NMRA if I cease to act in the capacity of responsible pharmacist within 28 days of the date that I cease to do so.

Name:

SLMC Registration Number:

Designation:

....

Signature Date

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Details of the Responsible Pharmacist

Name:

SLMC Registration Number:

Designation:

Details of the Previous Employment (If applicable)

Pharmacy / Premises Name	Address	Duration
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

I accept my appointment as responsible pharmacist and declare that the business of the said wholesale/ retail pharmacy / wholesale, so far as it concerns the keeping, preparing, dispensing, and supplying of medicinal products, other than products on the general sale list, will be under my management. The retail sale of medicinal products will be undertaken with a responsible pharmacist in charge of the business at these premises. The responsible pharmacist will be either myself or any other qualified pharmacist who is subject to my directions.

.....
Signature

.....
Date