MIZORAM STATE PHARMACY COUNCIL

PHARMACY SUPERVISION QUARTERLY REPORT FORM

Month _____ to _____ Date _____

Name of Pharmacist : _____

Registration No. : _____

Name of Pharmacy supervised : _____

Name of Licensee : _____

Licence No. : _____

Location of Pharmacy : _____

1. Licensee present or absent: Present ☐ Absent ☐
   If absent, reason for absence

   _____

   _____

2. No. of visits in a month: _____

3. No. of hours spent in pharmacy : _____

4. Does prescription reach the Pharmacist?

   Yes ☐ No ☐

5. Do you give enough instructions to the licensee about the drug store management?

Yes ☐ No ☐

If yes, what are the instructions given?

_____

_____

6. Whether drugs under Schedule H1, especially antibiotics and habit forming drugs are possessed, stored and issued in accordance with the conditions of licence:

Yes ☐ No ☐

7. Whether medicines are stored under proper storage conditions:

Yes ☐ No ☐

8. Whether pharmacy is opened regularly or not:

Yes ☐ No ☐

9. Is supervision done by you or other Pharmacist (for Pharmacist not in Mizoram):

Myself ☐ Other Pharmacist ☐

Signature of Pharmacist
with seal

Signature of Licensee