DISTRIBUTOR / STOCKIST APPOINTMENT APPLICATION FORM

1	**Date of Proposal:**	
2	Name of the Party :	
3	Nature of Business : (Proprietorship/Partnership/ Company)	
4	Name of the Proprietor / Mobile No.:	
5	Address of Business (Pin code is must) :	
6	Availability of :	Computer _____ Internet : _____
7	Contact Nos.:	Code: Ph. /Mobile No.:
		E-Mail :
8	Address of warehouse : (If Separate from office)	
9	Whether office or Warehouse is leased/owned (If leased, Please submit rent deed copy)	
10	Mention the details of infrastructure in Warehouse along with Temperature control mechanism in storage area:	
11	Whether related to any one in Venus Remedies Limited :	
12	VAT/CST NO. : (Kindly attach certificate copy)	
13	DL NO. 20B & 21 B:(Kindly attach certificate copy)	
14	PAN NO. :(Kindly attach certificate copy)	
15	Year of establishment :	
16	Proposed Coverage area :	
17	Address of Branches / Sister concerns (If any)	
18	Capital employed (in Lacs)	

19	Annual Turnover (In Lacs)	
20	Name of Banker with Address :	
21	Bank A/C No. :	
22	Name of Authorized Signatory	
23	Name of Companies being serviced as Stockist / Distributor (For OTC -mention the **Brand** also)	
24	Details of Persons / Employee who will be assigned for Venus transactions :	
25	No. of Field Personnel employed :	
26	Total No. of Parties/Retailers serviced by the firm :	
27	Distribution Facilities:	

TERMS & CONDITIONS :

- **PAYMENT TERMS 100 % ADVANCE.**
- **WE DO NOT AUTHORIZE CASH/GOODS TRANSACTIONS WITH OUR FIELD PERSONNEL & YOU WILL BE SOLELY RESPONSIBLE FOR SUCH TRANSACTIONS AND LIABILITIES ARISING OUT OF THESE.**
- **STORAGE CONDITIONS SHOULD BE IN COMPLIANCE WITH THE STATUTORY REQUIREMENTS AS WELL AS THE NATURE OF MEDICINES.**
- **SHORT EXPIRY HAS TO BE INFORMED AT LEAST SIX MONTHS IN ADVANCE.**
- **GOODS RETURN AGAINST EXPIRIES HAVE TO COMPLY WITH PREVAILING NORMS OF A.I.O.C.D.**
- **THE COMPANY (VRL) IS AUTHORIZED TO APPOINT NEW/ADDITIONAL STOCKISTS AS PER THE NEED OF THE BUSINESS.**

I/WE AGREE TO THE ABOVE & PROMISE TO COMPLY WITH ALL THE ABOVE MENTIONED TERMS.

AUTHORIZED SIGNATORY
(WITH THE SEAL OF THE FIRM)

VENUS REMEDIES LIMITED

TO BE FILLED BY REPRESENTATIVE OR RESPECTIVE HEAD:

Name of B.O/B.E./ABM :					
TEAM: (Saaransh / Mark IIID/ Critical Care Division / OTC)			**H.Q:**		
Detail of the existing Stockists in H.Q:					
Stockist Name, Station	**Avg. Pri. Sale (Last 3 Months) (Rs.)**	**Avg. Sec. Sale (Last 3 Months) (Rs.)**	**Stock as of Previous Months end* (Rs.)**	**1st Invoice (Month / Year)**	**Last Invoice (Month / Year)**
Note: If proposal date is between 25 th to 30 th then provide the current month stock value.					

In case of Replacement Stockist :		
Name of stockist to be Replaced:	**Stocks value at the stockist to be replaced.**	**Liquidation plan & deadline of the stocks available at stockist to be replaced:**
If, Proposal is for add. Stockist, kindly attach the NOC (Wherever Applicable)		
Reasons for New Appointment :		
Value of the 1st Order		
Expected Business:		
Name of Distributor :(In case of stockist approval, supplies will be from)		
Remarks of Reporting Head of the initiator of Proposal with Signature:		
Remarks of CPIC Manager with Signature:		
Remarks of Marketing Head with Signature:		
Remarks of Management Head with Signature:		