सत्यमेव जयते IPC	**INDIAN PHARMACOPOEIA COMMISSION** **National Coordination Centre-Pharmacovigilance Programme of India**
	Annexure-VI **Reimbursement Claim Form**

Format No. IPC/PvPI/TE/002-F06-00

REIMBURSEMENT CLAIM FORM

Name of the AMC:
Complete postal Address:
State:

Details of Coordinator:
Name:
Email Id:
Phone No:

Details of Dy. Coordinator:
Name:
Email Id:
Phone No:

Name of Pharmacovigilance Associate:
Email Id & Phone no:
Date of Joining:

S. No.	Bill/Voucher No. with date	Particulars	Purpose	Amount
			Grand Total	

This is to certify that the above said expenditure was incurred by me for smooth functioning of AMC, during financial year ……

Check List:
1. Original bills along with covering letter.
2. Original bills countersigned by the coordinator.
3. Cash Memos will not be entertained.
4. Mention the updated Account details (Account Name, Account Number, IFSC Code, and Branch Name) for the reimbursement.

Sign of Pharmacovigilance Associate. **Signature of AMC Coordinator with Stamp**

	Name	Designation	Signatures	Date	Page
Prepared by					**1** of **1**
Reviewed by					
Approved by					