PRESCRIPTION DRUG REPOSITORY PROGRAM

Donor Form

Donor Information

Name – Donor	Date of Birth – Donor (mm/dd/yyyy)	Date Donated *(mm/dd/yyyy)*	
Phone Number – Donor	MRN – Donor (If Applicable)		
Street Address	City	State	Zip Code

RECEIPIENT INFORMATION - Name of Pharmacy or Health Care Facility (Central or Local Repository) Receiving Donation

Phone Number – Facility or Pharmacy

DRUG / MEDICAL SUPPLY INFORMATION*

Name of Drug or Medical Supply	Strength	Manufacturer	Expiration Date or Beyond Use Date ^ (When Known)	Quantity Donated*	Lot Number (When Known)

* Additional items can be listed on the back of this form. The information concerning each drug or medical supply may be listed on the back of this form or on an additional sheet, provided the additional sheet is kept with this form.
^ Drugs or medical supplies that are expired or past their beyond-use date cannot be donated.

Attestation

I attest that, to the best of my knowledge, the drugs or supplies listed on this form have been properly stored under appropriate temperature & humidity conditions, and that the drug or supply has never been opened, used, tampered with, adulterated (unclean or unsanitary conditions), or misbranded (change its labeling in a false or misleading manner).

SIGNATURE – Donor	Date Signed *(mm/dd/yyyy)*

Name of Pharmacist Accepting Donation

License # of Pharmacist