

DRUG DESTRUCTION INVENTORY



Date: _____, 20__

Keep on file with Controlled Drug records

Facility Address City State Zip

NAME OF DRUG OR PREPARATION	QUANTITY

This is to certify that I have destroyed these drugs.

Date: _____, 20__
_____ Signature of registrant or authorized agent

This is to certify that I have witnessed the destruction of these drugs.

Date: _____, 20__
_____ Signature of registrant or authorized agent