

Medication Donation Form

Donor Information

Name: _____ Telephone: (____) _____

Address: _____ State: _____ Zip Code: _____

Drug Name	Drug Strength	Qty	Lot #	Expiration Date

By signing below, I attest that to the best of my knowledge the drug(s) listed above have been properly stored, in accordance with the manufacturer's recommendations, and have never been opened, used, adulterated or misbranded. They have been in the possession of:

Patient
 Donor
 Other: _____; since originally dispensed.

Donor Signature: _____ Date: ____/____/____

For Pharmacy Use

Is the medication in the original sealed container or in a sealed bubble pack?	YES	NO
Is the medication available over-the-counter?	YES	NO
Is the medication a controlled substance?	YES	NO
Does the medication require refrigeration?	YES	NO
Does the medication expire in less than 9 months?	YES	NO
Does the medication appear safe for dispensing?	YES	NO

Pharmacist Signature: _____ Date: ____/____/____