# BICILLIN DISTRIBUTION TRACKING FORM

***LPHAs: Please complete this form. Provide your community partner a copy with the Bicillin delivery, and retain a copy for your records. Please fax a copy to the Oregon STD Program (971-673-0178).***

| Drug (container and strength) | Quantity (# of syringes) | Lot Number(s) | Expiration Date(s) | Delivery Date (to the community partner) |
|---|---|---|---|---|
| Bicillin (1.2mu/2ml syringe) | | | | |

**Clinic / Provider:** _____

Contact Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

**LPHA:** _____

Contact Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

*For State Use*

Orpheus case(s) if available:

_____
_____
_____
_____
_____

Oregon STD Program
800 NE Oregon St, Ste 1105
Portland, OR 97232
Phone: 971-673-0152
Fax: 971-673-0178

OREGON STD PROGRAM

Oregon Health Authority

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