

# OREGON CHARITABLE PHARMACY Donor Registration Form

Donor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Name of Patient for Whom the drug was originally prescribed:  
\_\_\_\_\_

**All drugs must be in their original, sealed, tamper-evident packaging**

### DRUG(s) Donated

Drug Name	Drug Strength	Quantity	Lot #	Expiration Date	Original Pharmacy

By signing below, I attest that to the best of my knowledge the drug(s) listed above have been properly stored, in accordance with 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.

Date Donated \_\_\_\_\_

Date Received \_\_\_\_\_

Donor Signature: \_\_\_\_\_

Received By: \_\_\_\_\_