

CANCER AND CHRONIC DISEASES DRUG REPOSITORY PROGRAM DONATION, TRANSFER AND DESTRUCTION RECORD

Completion of this form meets the requirements of Wisconsin Administrative Codes HFS 148.06(2)(a)1. and (b)3. for donating drugs and supplies, HFS 148.09(3) for distribution of drugs or supplies to a participating repository and HFS 148.11(2) for destruction of drugs and supplies. Questions about completion of this form may be directed to 608-266-5388.

DONATION INFORMATION	
-----------------------------	--

Name – Donor (print or type)		Date Donated
Name – Pharmacy or Medical Facility Receiving Donation		
Name – Medication or Medical Supply		
Medication Strength	Expiration Date	Quantity Donated

I certify that the above named medication or medical supply was stored as recommended by the manufacturer and has not been tampered with.

SIGNATURE – Donor	Date Signed
--------------------------	-------------

DRUG OR MEDICAL SUPPLY TRANSFER INFORMATION	
--	--

Name – Pharmacy or Medical Facility Receiving Drug or Medical Supply	Date Transferred
Quantity of Medication or Description of Medical Supply Transferred	

CHECK ONE OF THE FOLLOWING:

- The original donation form is being sent with the transferred medication or medical supply if the ENTIRE original donation is transferred.
- A COPY of the original donation form is being sent with the transferred medication if the original donation is partially transferred.

DESTRUCTION INFORMATION	
--------------------------------	--

Name – Medication	Quantity Destroyed
SIGNATURE – Person Destroying Medication	Date Destroyed