**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Quality Assurance

F-62645C (05/2020)

**DRUG REPOSITORY PROGRAM – DESTRUCTION RECORD**

* Completion of this form meets the requirements of Wisconsin Administrative Code § DHS 148.11(2) for destruction of drugs and medical supplies.
* Questions about completion of this form may be directed to **608-266-5388.**

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| **PHARMACY OR MEDICAL FACILITY INFORMATION** |
| Name – Pharmacy or Medical Facility | Date Destroyed *(MM/dd/yyyy)*      |
| Street Address      | City      | State   | Zip Code      |
| Name – Person Destroying Drugs or Medical Supplies      |
| **DRUG / MEDICAL SUPPLY INFORMATION** |
| **Name of Drug or Medical Supply** | **Strength** | **NDC No.** | **Lot No.** | **Expiration Date** | **Quantity Destroyed** |
| 1. |       |       |       |       |       |       |
| 2. |       |       |       |       |       |       |
| 3. |       |       |       |       |       |       |
| 4. |       |       |       |       |       |       |
| 5. |       |       |       |       |       |       |
| 6. |       |       |       |       |       |       |
| 7. |       |       |       |       |       |       |
| 8. |       |       |       |       |       |       |
| 9. |       |       |       |       |       |       |
| 10. |       |       |       |       |       |       |
|  |
| **SIGNATURE** –Person Destroying Drugs or Medical Supplies | Date Signed *(MM/dd/yyyy)*      |