PRESCRIPTION DRUG DONATION PROGRAM
REPOSITORY PARTICIPATION OR WITHDRAWAL FORM

- Questions about completion of this form may be directed to the Bureau of Public Health Pharmacy at (850) 841-8530.

APPLICATION – PHARMACY OR MEDICAL FACILITY		
Name of Pharmacy or Medical Facility (Print)	Facility Telephone Number	
License/Registration Number (If Applicable)	Website (If Applicable)	
License/Registration Issuing Agency		
Address	Email address	
City	State	ZIP Code
Name-Pharmacist (Print)	Telephone Number	
Type of Facility (check one of the following): __ Nursing home facility with closed drug delivery system __ Hospital with closed drug delivery system __ Pharmacy __ Health Care Practitioner's office __ Free clinic or nonprofit health clinic licensed or permitted to dispense medicinal drugs in the state		

I attest that the above-named facility is licensed in the State of Florida and complies with all applicable state and federal laws and administrative rules, including the requirements of section 465.1902, Florida Statutes.

SIGNATURE- Responsible Pharmacist ➢	Date Signed

NOTICE OF WITHDRAWAL – PHARMACY OR MEDICAL FACILITY		
Name of Pharmacy or Medical Facility	Telephone Number	
Address		
City	State	ZIP Code

I attest that, as of _____, the pharmacy or medical facility identified above will no longer be
(Date)
participating in the Prescription Drug Donation Repository Program.

SIGNATURE- Responsible Pharmacist ➢	Date Signed

Submit this form to: PrescriptionDrugDonationProgram@FLHealth.gov and indicate in the subject line "Repository Participation or Withdrawal Form" or mail to: DOH Bureau of Public Health Pharmacy, Drug Donation Program, 104-2 Hamilton Park Dr., Tallahassee, FL 32304.