



PRESCRIPTION DRUG DONATION PROGRAM TRANSFER FORM

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

TRANSFERRING PHARMACY OR MEDICAL FACILITY INFORMATION					
Name- Pharmacy or Medical Facility (Print)				Date of Transfer (MM/DD/YYYY)	
Street Address			Email Address		
Facility Phone Number	City		State	ZIP Code	
RECEIVING PHARMACY OR MEDICAL FACILITY INFORMATION					
Name- Pharmacy or Medical Facility				Date of Transfer (MM/DD/YYYY)	
Street Address			Email Address		
Facility Phone Number	City		State	ZIP Code	

DRUG/MEDICAL SUPPLY INFORMATION					
Drug Name or Medical Supply	Strength	NDC No.	Lot No.	Exp. Date	Qty

I attest that the above-named repository receiving the transferred drugs or supplies is a participant in the Prescription Drug Donation Repository Drug Program.

Print Name (Pharmacist)	Signature (Pharmacist)	Date
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Submit this form to: PrescriptionDrugDonationProgram@FLHealth.gov and indicate in the subject line "Transfer Form" or mail to: DOH Bureau of Public Health Pharmacy, Drug Donation Program, 104-2 Hamilton Park Dr., Tallahassee, FL 32304

DRUG/MEDICAL SUPPLY INFORMATION

Drug Name or Medical Supply	Strength	NDC No.	Lot No.	Exp. Date	Qty