



**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) 922-9036.

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): <input type="checkbox"/> Nursing home facility with closed drug delivery system <input type="checkbox"/> Hospital with closed drug delivery system <input type="checkbox"/> Pharmacy <input type="checkbox"/> Health Care Practitioner’s office <input type="checkbox"/> 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
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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 participating in the Prescription Drug Donation Repository Program.
(Date)

SIGNATURE- Responsible Pharmacist ➤	Date Signed
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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.