



PRESCRIPTION DRUG DONATION PROGRAM DONATION FORM

All donors must obtain written approval* from a participating repository prior to shipping any donated drugs or supplies.

Hand delivery, overnight or 2-day shipping is strongly encouraged once approval is obtained.

- Questions about completion of this form may be directed to the Bureau of Public Health Pharmacy at (850) 922-9036.

DONOR INFORMATION				
Name-Donor (Print)			Date Donated (MM/DD/YYYY)	
Phone Number	Street Address		Email address	
City			State	ZIP Code
Indicate type of facility making donation: (check one)				
<input type="checkbox"/> Nursing Home			<input type="checkbox"/> Hospital	
<input type="checkbox"/> Hospice (that have maintained control of a patient's Rx's)			<input type="checkbox"/> Drug Manufacturer	
<input type="checkbox"/> Pharmacy			<input type="checkbox"/> Medical Device Manufacturer or Supplier	
			<input type="checkbox"/> Prescriber (procured from a manufacturer, wholesaler, or pharmacy)	
RECIPIENT INFORMATION				
Name of Pharmacy or Medical Facility <i>Receiving</i> Donations				

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

By signing below, I verify that all the drugs or supplies being donated meet the program eligibility requirements, including the criteria of sections 465.1902(5) and (6), Florida Statutes.

Print Name (Inspecting Pharmacist)	Signature (Inspecting Pharmacist)	Date
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This form must be retained on file by the receiving repository.

*Written approval may be in the form of an email.

