

## DRUG REPOSITORY PROGRAM NOTICE OF PARTICIPATION OR WITHDRAWAL

- Completion of this form meets the notification requirement for participation in, or withdrawal from, the Drug Repository Program under Chapter DHS 148.04(2) and (3), Wis. Admin. Code.
- Complete and submit this form to the following address:  
**Drug Repository Program**  
**Division of Quality Assurance**  
**PO Box 2969**  
**Madison, WI 53701-2969**  
or FAX to **608-267-7119**
- Questions about completing this form may be directed to **608-266-5388**.

### NOTICE OF PARTICIPATION - PHARMACY OR MEDICAL FACILITY

A pharmacy or medical facility may fully participate in the drug repository program by accepting, storing and dispensing donated drugs and supplies or may limit its participation to only accepting and storing donated drugs and medical supplies. Check one of the following:

- Full Participation (Will dispense drugs and supplies)       Partial Participation (Will **not** dispense drugs and supplies)

Name – Pharmacy or Medical Facility		Telephone Number	
Address			
City		State	Zip Code
Name – Pharmacist or Designee		Telephone Number	

I attest that the above named facility is licensed in the State of Wisconsin and is in compliance with all applicable state and federal laws and administrative rules.

<b>SIGNATURE</b> – Pharmacist or Designee  ➤	Date Signed
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### NOTICE OF WITHDRAWAL - PHARMACY OR MEDICAL FACILITY

Name – 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  
(Date)  
the Drug Repository Program.

<b>SIGNATURE</b> – Pharmacist or Designee  ➤	Date Signed
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