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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-62645 (05/2020) | | | | | | **STATE OF WISCONSIN** | | | | |
| **DRUG REPOSITORY PROGRAM – RECIPIENT RECORD** | | | | | | | | | | |
| * Completion of this form meets the requirement of Wisconsin Administrative Code DHS 148.07(3) for dispensing drugs or medical supplies to recipients who meet the eligibility requirements of DHS 148.05. * Questions about completion of this form may be directed to **608-266-5388**. | | | | | | | | | | |
| **RECIPIENT INFORMATION** | | | | | | | | | | |
| Name – Recipient | | | | | | | Date Received *(MM/dd/yyyy)* | | | |
| Address | | | City | | | | State | | Zip Code | |
| **NOTE:** The dispensing pharmacy or medical facility may place a copy of the label on this form in lieu of entering the following information. | | | | | | | | | | |
| **DRUG / MEDICAL SUPPLY INFORMATION** | | | | | | | | | | |
| **Name of Drug or Medical Supply** | | **Strength** | | **NDC No.** | **Lot No.** | | | **Exp. Date** | | **Qty. Rec’d** |
| 1. |  |  | |  |  | | |  | |  |
| 2. |  |  | |  |  | | |  | |  |
| 3. |  |  | |  |  | | |  | |  |
| 4. |  |  | |  |  | | |  | |  |
| 5. |  |  | |  |  | | |  | |  |
| 6. |  |  | |  |  | | |  | |  |
| 7. |  |  | |  |  | | |  | |  |
| 8. |  |  | |  |  | | |  | |  |
| **ATTESTATION** | | | | | | | | | | |
| I attest that I am a resident of the State of Wisconsin and that I meet the eligibility requirements as listed in Wisconsin Administrative Code § DHS 148.05. I understand that the drug or medical supply that I am receiving has been donated and has potentially been stored in a non-controlled environment. I attest that I have verbally been notified that this drug or medical supply may have been previously dispensed. I understand that the pharmacy, pharmacist, and manufacturer cannot be held liable for problems with this drug or medical supply that has been accepted for donation and dispensed *in good faith*. | | | | | | | | | | |
| **SIGNATURE** – Recipient | | | | | | | Date Signed *(MM/dd/yyyy)* | | | |