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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-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**.
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| **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)*      |