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)*
➢	