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**.

Name – Recipient *(Print or type.)*	Date Received

NOTE: The pharmacy may place a copy of the label on this form in lieu of entering the following information.

Name – Medication		
Medication Strength	Expiration Date	Quantity Received

I attest that I am a Wisconsin Resident and that I understand that the medication I am receiving has been donated and has potentially been stored in a non-controlled environment. I understand that the pharmacy, pharmacist, and manufacturer cannot be held liable for problems with this medication that has been accepted for donation and dispensed in good faith.

SIGNATURE – Recipient	Date Signed
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