**5DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Quality Assurance

F-62645B (05/2020)

**DRUG REPOSITORY PROGRAM – DONATION RECORD**

* Completion of this form meets the requirements of Wisconsin Administrative Code §§ DHS 148.06(2)(a)1 and (b)3 for donating drugs and medical supplies.
* Questions about completion of this form may be directed to **608-266-5388.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DONOR INFORMATION** | | | | | | | | | | |
| Name – Donor | | | | | | Date Donated *(MM/dd/yyyy)* | | | | |
| Street Address | | | | City | | State | | | Zip Code | |
| **RECIPIENT INFORMATION** | | | | | | | | | | |
| Name – Pharmacy or Medical Facility Receiving Donations | | | | | | | | | | |
| **DRUG / MEDICAL SUPPLY INFORMATION** | | | | | | | | | | |
| **Name of Drug or Medical Supply** | | **Strength** | **NDC No.** | | **Lot No.** | | **Expiration Date** | | | **Quantity**  **Donated** |
| 1. |  |  |  | |  | |  | | |  |
| 2. |  |  |  | |  | |  | | |  |
| 3. |  |  |  | |  | |  | | |  |
| 4. |  |  |  | |  | |  | | |  |
| 5. |  |  |  | |  | |  | | |  |
| 6. |  |  |  | |  | |  | | |  |
| 7. |  |  |  | |  | |  | | |  |
| 8. |  |  |  | |  | |  | | |  |
| 9. |  |  |  | |  | |  | | |  |
| 10. |  |  |  | |  | |  | | |  |
| **ATTESTATION** | | | | | | | | | | |
| I attest that the above-named drugs or medical supplies were stored as recommended by the manufacturer and have not been subject to tampering. | | | | | | | | | | |
| **SIGNATURE** –Donor | | | | | | | | Date Signed *(MM/dd/yyyy)* | | |