**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.**

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| **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)*      |