PRESCRIPTION DRUG REPOSITORY PROGRAM – DONOR FORM

- **Completion of this form meets the donor documentation requirements under Minnesota Statute 151.555 for donating drugs and supplies to a participating repository under the Prescription Drug Repository Program. This form must be maintained for at least five years.**

- **Questions about completing this form may be directed to [NAME OF CR] at [PHONE # OF CR]**

DONOR INFORMATION

Name – Donor		Date Donated *(MM/dd/yyyy)*	
Street Address	City	State	Zip Code

RECIPIENT INFORMATION

Name – Pharmacy or Health Care Facility (Central or Local Repository) Receiving Donation

DRUG / MEDICAL SUPPLY INFORMATION*

Name of Drug or Medical Supply*	Strength*	Manufacturer*	Expiration Date or Beyond Use Date*^ (when known)	Quantity Donated*	Lot Number* (when known)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

ATTESTATION

I attest that, to the best of my knowledge, the drugs or supplies listed on this form have been properly stored under appropriate temperature & humidity conditions, and that the drug or supply has never been opened, used, tampered with, adulterated, or misbranded.

SIGNATURE – Donor ➢	Date Signed *(MM/dd/yyyy)*

* Additional items can be listed on the back of this form. The information concerning each drug or medical supply may be listed on the back of this form or on an additional sheet, provided the additional sheet is kept with this form.

^ Drugs or medical supplies that are expired or past their beyond-use date cannot be donated.

Name of Pharmacist Accepting Donation _____ **License # of Pharmacist** _____