

**SIRUM****Fax this sheet to (888) 858-8172****1. BY SIGNING BELOW, I attest that to the best of my knowledge the donated drug(s)**

A) have been properly stored, in accordance with the manufacturer's recommendations, and have never been opened, used, adulterated or misbranded AND

B) since originally dispensed, the donated drug(s) have been in the possession of a pharmacy, skilled nursing facility, intermediate care facility or trained staff.

**2. PICKUP LOCATION**

Front Office      Nursing Station      DON Office      Other \_\_\_\_\_

NAME Jackie Dean TITLE Purchasing Supervisor CELL # (optional) (    ) \_\_\_\_\_SIGNATURE Jackie Dean DATE 8-20-15 TOTAL # OF BOXES 1

Peel Label HERE →

**CIRCLE SUPPLIES NEEDED** (optional)

Shipping Labels

Boxes

Padded envelopes

Packing tape

Sharpies

**THANK YOU! FEDEX WILL COME  
THE NEXT BUSINESS DAY**

Tracking #971424215098192 - D755R719T5765P

Consonus Pharmacy Services  
4560 Se International Way, Suite 101, Milwaukie,  
OR 97222Central City Concern Pharmacy  
727 W Burnside St, Portland, OR 97209

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# Medication Donation Form

## Donor Information

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

| Drug Name | Drug Strength | Qty | Lot # | Expiration Date |
|-----------|---------------|-----|-------|-----------------|
|           |               |     |       |                 |
|           |               |     |       |                 |
|           |               |     |       |                 |
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|           |               |     |       |                 |
|           |               |     |       |                 |

By signing below, I attest that to the best of my knowledge the drug(s) listed above have been properly stored, in accordance with the manufacturer's recommendations, and have never been opened, used, adulterated or misbranded. They have been in the possession of:

☐ Patient    ☐ Donor    ☐ Other: \_\_\_\_\_; since originally dispensed.

Donor Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### For Pharmacy Use

Is the medication in the original sealed container or in a sealed bubble pack?      **YES**      **NO**

Is the medication available over-the-counter?      **YES**      **NO**

Is the medication a controlled substance?      **YES**      **NO**

Does the medication require refrigeration?      **YES**      **NO**

Does the medication expire in less than 9 months?      **YES**      **NO**

Does the medication appear safe for dispensing?      **YES**      **NO**

Pharmacist Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_