

## 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, or intermediate care facility.

**2. PICKUP LOCATION**

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

NAME \_\_\_\_\_ TITLE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ TOTAL # OF PAGES \_\_\_\_\_

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727 W Burnside St.  
  
Portland, OR 97209  
(650) 488-7434

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Dept.

**CIRCLE SUPPLIES NEEDED** (optional)**Shipping Labels**

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Sharpies

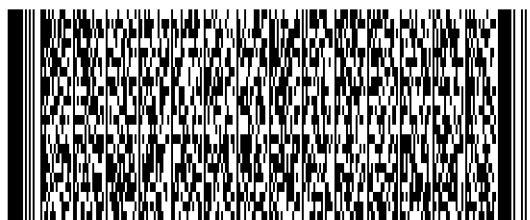
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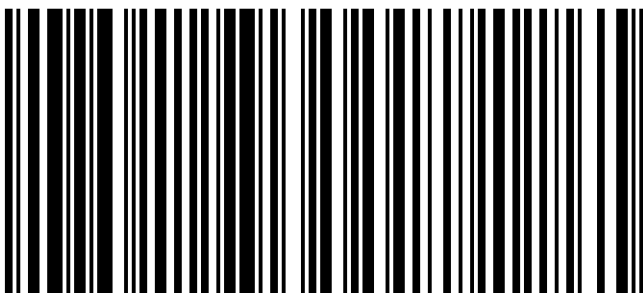
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