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, adultered 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 No Need - We Already have them picking up
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 #971424215098178 - D755R719T5763P

Consonus Pharmacy Services
4560 Se International Way, Suite 101, Milwaukie, OR 97222

Central City Concern Pharmacy
727 W Burnside St, Portland, OR 97209

Prepaid

Medication Donation Form

Donor Information

Name: _____ Telephone:(_____)_____

Address:_____ State:_____ Zip Code:_____

Drug Name	Drug Strength	Qty	Lot #	Expiration Date

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, adultered 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:____/____/____