REPUBLIC OF KENYA

MINISTRY OF HEALTH

MEDICALLY ASSISTED THERAPY (METHADONE) PRODUCT(S) RECEIPT AND INSPECTION FORM

FORM P1a

County..... Sub County..... Site/ Facility.....

Date/Month/Year..... Time…….. MFL Code.....

Implementing partner……

Product Name: …… Form …… (Liquid/powder) Quantity: …….. Bottle/Tin Strength: …….. Grams per Bottle/Tin

Consignment Number: …… Goods Received Note Number: …… Vehicle Registration Number: ……..

Consignee: …… Address: ……

Product Inspection:

	Yes/NO	If **No**, Give Details
Is the delivery note/ invoice for your facility?	1=Yes ☐ 2. No ☐	……
Are the goods delivered, the ones that were ordered?	1=Yes ☐ 2. No ☐	……
Are the quantities delivered those in the delivery note or invoiced.	1=Yes ☐ 2. No ☐	……
Is the condition of the boxes at the time of delivery acceptable?	1=Yes ☐ 2. No ☐	……
Are the goods delivered in good condition (check liquids for leakages, broken containers, unsealed, unusual odors)	1=Yes ☐ 2. No ☐	……
Is expiry date of products acceptable for your facility	1=Yes ☐ 2. No ☐	……
Document any discrepancies and follow up with supplier		

_____	_____	_____	____/____/_____
Name (MAT Clinic Pharmacist)	ID Number	Signature	Date
_____	_____	_____	____/____/_____
Name (Facility Pharmacist In charge)	ID Number	Signature	Date
_____	_____	_____	____/____/_____
Name (PPB Representative/County Pharmacist)	ID Number	Signature	Date