REPUBLIC OF KENYA

MINISTRY OF HEALTH

MEDICALLY ASSISTED THERAPY (METHADONE) PRODUCT STORAGE FORM

FORM P1b

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

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

Implementing partner……

Product Storage Form

Product Stored by Pharmacist:

_____	_____	_____	____/_____/_____
Name (MAT Clinic Pharmacist)	ID Number	Signature	Date

Product (s) Storage Witnesses

_____	_____	_____	____/_____/_____
Name (Facility Pharmacist in Charge)	ID Number	Signature	Date
_____	_____	_____	____/_____/_____
Name (PPB Representative/County Pharmacist)	ID Number	Signature	Date
_____	_____	_____	____/_____/_____
Name (Police/Security)	Force Number	Signature	Date