PRESCRIPTION DRUG DONATION PROGRAM
DONATION FORM

All donors must obtain written approval* from a participating repository prior to shipping any donated drugs or supplies.

Hand delivery, overnight or 2-day shipping is strongly encouraged once approval is obtained.

- Questions about completion of this form may be directed to the Bureau of Public Health Pharmacy at (850) 841-8530.

DONOR INFORMATION				
Name-Donor (Print)				Date Donated (MM/DD/YYY)
Phone Number	Street Address	Email address		
City			State	ZIP Code

Indicate type of facility making donation: (check one)

- ☐ Nursing Home
- ☐ Hospice (that have maintained control of a patient's Rx's)
- ☐ Pharmacy
- ☐ Hospital
- ☐ Drug Manufacturer
- ☐ Medical Device Manufacturer or Supplier
- ☐ Prescriber (procured from a manufacturer, wholesaler, or pharmacy)

RECIPIENT INFORMATION

Name of Pharmacy or Medical Facility ***Receiving*** Donations

DRUG/MEDICAL SUPPLY INFORMATION

Drug Name or Medical Supply	Strength	NDC No.	Lot No.	Expiration Date	Quantity

By signing below, I verify that all the drugs or supplies being donated meet the program eligibility requirements, including the criteria of sections 465.1902(5) and (6), Florida Statutes.

Print Name (Inspecting Pharmacist) **Signature** (Inspecting Pharmacist) **Date**

This form must be retained on file by the receiving repository.

*Written approval may be in the form of an email.

DRUG/MEDICAL SUPPLY INFORMATION					
Drug Name or Medical Supply	**Strength**	**NDC No.**	**Lot No.**	**Expiration Date**	**Quantity**