VOLUNTEERS IN MEDICINE
CLINIC OF THE CASCADES

OREGON CHARITABLE PHARMACY DONOR FORM

Name of Patient for Whom the Drug was Originally Prescribed:
Donor's Name:
Address:
Telephone:

All drugs must be in their original, sealed, tamper-evident packaging

By signing below, I attest that to the best of my knowledge the drug(s) listed above have been properly stored, in accordance with manufacturer's recommendations, and have never been opened, used, adulterated or misbranded. They have been in the possession of:
Patient _____ Donor _____ Other _____, since originally dispensed

Date Donated:
Date Received:
Pharmacist Received/Check:

DRUG(s) Donated

Drug Brand Name	**Generic Name**	**Drug Strength**	**Quantity**	**Lot #**	**Expiration Date**
Date dispensed	Prescription #	# dispensed	# remaining	Lot #	Verified by

Donor Signature_____ Date_____

updated 09/14