[INSERT CLINIC NAME]

[INSERT CLINIC ADDRESS]

[INSERT CLINIC CONTACT INFORMATION]

**Medication Donation Form**

**Donor Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Donor Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Donor Phone Number** \_\_(\_\_\_\_)\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_ **Date of Donation** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Medication Name** | **Strength** | **Expiration Date** | **Total # of Items/Pills** | **RPh Reviewed (Clinic Use Only)** |
| --- | --- | --- | --- | --- |
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By signing my name below, I confirm that these drugs have been properly stored in accordance with the manufacturer’s recommendations. I have removed or redacted any patient name, prescription number, and/or other patient identifying information on the drugs.

**Donor Signature:**

Valuation of donated medications and supplies is the responsibility of the donor. Visit the IRS website for guidance.

[INSERT CLINIC NAME] is a 501c3 organization.

Clinic Staff Only:

\_\_\_\_\_\_ Reviewed expiration date

\_\_\_\_\_\_ Not controlled substances

\_\_\_\_\_\_ Tamper evident packaging

\_\_\_\_\_\_ Staff initials