

**DRUG REPOSITORY PROGRAM
RECIPIENT RECORD**

- Completion of this form meets the requirement of the variance approved by SD Board of Pharmacy to rule: ARSD 20:51:12:02 Return of unused drugs effective 7/1/2019 for dispensing drugs or medical supplies to recipients who meet the eligibility requirements.
- Questions about completion of this form may be directed to 605-322-8300.

Name – Recipient

Date Received

NOTE: The pharmacy may place a copy of the label on this form in lieu of entering the following information.

Name – Medication

Medication Strength

Expiration Date

Quantity Received

NDC

Lot Number

- I attest that I understand that the medication I am receiving has been donated and has potentially been stored in a non-controlled environment.
- I understand that the pharmacy, pharmacist, and manufacturer cannot be held liable for problems with this medication that has been accepted for donation and dispensed in good faith.
- I understand that the pharmacy is providing the medication free-of-charge, that my insurance will not be charged any amount for this specific fill and I am not personally being charged any fee for the service.
- I understand that this is a one-time transaction dependent on the supply of donated inventory, that there is no guarantee or expectation of the pharmacy to provide a subsequent fill free of charge.

SIGNATURE – Recipient

Date Signed