Pharmaceutical Return Sheet

FACILITY/CODE NAME: _____ **Date:** _____

IT IS IMPERATIVE THAT THIS FORM IS COMPLETED ON ALL RETURNED/DESTROYED MEDICATIONS. BE SURE TO MAINTAIN A COPY OF THIS FORM TO ENSURE PROPER DOCUMENTATION IS ON FILE AT YOUR SITE.

Rx #	Inmate Name	Medication	Quantity	Returned	Destroyed

Signature of person releasing/destroying medication: _____ Date: _____

Signature of person releasing/destroying medication: _____ Date: _____

Do Not Fax this form to Pharmacy Vendor. Return forms are to be placed in the box with the return meds. KOP meds are to be boxed separately.

DOC 140130E (R 12/21)