

**CANCER DRUG REPOSITORY PROGRAM
DONATION, TRANSFER AND DESTRUCTION RECORD**

Completion of this form meets the requirements of Kansas Administrative Regulations K.A.R..... for donating drugs for distribution of drugs to a participating repository for destruction of drugs. Questions about completion of this form may be directed to (785) 296-4056 or on the Board's web-site at www.kansas.gov/pharmacy.

DONATION INFORMATION

Name-Donor (Print or Type)		Date Donated
Name-Pharmacy/Medical Facility/Entity Receiving Donation		
Name-Drug		
Drug Strength	Expiration Date	Quantity Donated

I certify that the above named drug was stored
As recommended by the manufacturer and has not been tampered with.

SIGNATURE-Donor

DRUG TRANSFER INFORMATION

Name-Pharmacy/Medical Facility/Entity Receiving Drug
Quantity of Drug Transferred

CHECK ONE OF THE FOLLOWING:

- The original donation form is being sent with the transferred drug if the ENTIRE original donation is transferred.
- A COPY of the original donation form is being sent with the transferred drug if the original donation is partially transferred.

DESTRUCTION INFORMATION

Name-Drug	Quantity Destroyed
SIGNATURE -Person Destroying Drug	Date Destroyed