North Dakota Prescription Drug and Device Donation Program

Recipient [Patient] Information

(copy of dispensing label with adequate information will suffice for these requirements)

Name of Pharmacy or Practitioner dispensing donated medication:

Name of recipient:

Address of recipient:

CITY STATE ZIP

Name, quantity, and expiration date of drugs received:

Prescription #s

I understand that the above named drug or device I am receiving has been donated, may have been previously dispensed, and has potentially been stored in a non-controlled environment.

Signature of recipient: Date Signed

* Please ask your pharmacist or physician if you have any other questions.

This form should be kept on file by the pharmacy or physician dispensing the medication. Inclusion in the patient chart meets this requirement.
This program is authorized by ND Century Code Chapter 43-15.2.