* Questions about completion of this form may be directed to the Bureau of Public Health Pharmacy at (850) 922-9036.

**Patient: Please complete the top portion of this form.**

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| **PATIENT INFORMATION** | | | | |
| Name- Patient (Print) | | | Date Received (MM/DD/YYYY) | |
| Address | | City | State | ZIP Code |
| Telephone number (home or work) | Telephone number (cell) | | Email Address | |
| This program requires that you meet one or more of the below criteria: (check all boxes that apply)   * Indigent (at or below 200% of federal poverty level) * Underinsured (drug or health care benefits have been exhausted, or no drug coverage, including an inability to afford the out-of-pocket expenses for the drug prescribed) * Uninsured (no health care coverage and not eligible for drug coverage under federal government program) | | | | |
| By signing below:  I affirm that I meet the eligibility requirements for this program, stated above, and that I will notify the repository if my eligibility changes.  I acknowledge that the prescription drug or supply I am receiving was donated to the program. Donors and participants in the program are immune from civil or criminal liability or disciplinary action. Eligible patients are not required to pay for the prescription drug or supply. | | | | |
| Signature of Patient: | | | | |

**Pharmacist completes the below information:**

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| DRUG/MEDICAL SUPPLY INFORMATION |

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| Drug Name or Medical Supply | Strength | NDC No. | Lot No. | Expiration Date | Quantity |
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Submit this form to: [PrescriptionDrugDonationProgram@FLHealth.gov](mailto:PrescriptionDrugDonationProgram@FLHealth.gov) or mail to: DOH Bureau of Public Health Pharmacy, Drug Donation Program, 104-2 Hamilton Park Dr., Tallahassee, FL 32304

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| Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DRUG/MEDICAL SUPPLY INFORMATION** (continued) |

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| Drug Name or Medical Supply | Strength | NDC No. | Lot No. | Expiration Date | Quantity |
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| **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DRUG/MEDICAL SUPPLY INFORMATION (continued) | | | | | |
| Drug Name or Medical Supply | **Strength** | **NDC No.** | **Lot No.** | **Expiration Date** | **Quantity** |
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