PRESCRIPTION DRUG DONATION PROGRAM
TRANSFER FORM

- Questions about completion of this form may be directed to the Bureau of Public Health Pharmacy at (850) 841-8530.

TRANSFERRING PHARMACY OR MEDICAL FACILITY INFORMATION			
Name- Pharmacy or Medical Facility (Print)			Date of Transfer (MM/DD/YYYY)
Street Address		Email Address	
Facility Phone Number	City	State	ZIP Code
RECEIVING PHARMACY OR MEDICAL FACILITY INFORMATION			
Name- Pharmacy or Medical Facility			Date of Transfer (MM/DD/YYYY)
Street Address		Email Address	
Facility Phone Number	City	State	ZIP Code

DRUG/MEDICAL SUPPLY INFORMATION					
Drug Name or Medical Supply	**Strength**	**NDC No.**	**Lot No.**	**Exp. Date**	**Qty**

I attest that the above-named repository receiving the transferred drugs or supplies is a participant in the Prescription Drug Donation Repository Drug Program.

Print Name (Pharmacist) **Signature** (Pharmacist) **Date**

Submit this form to: PrescriptionDrugDonationProgram@FLHealth.gov and indicate in the subject line "Transfer Form" or mail to: DOH Bureau of Public Health Pharmacy, Drug Donation Program, 104-2 Hamilton Park Dr., Tallahassee, FL 32304

DRUG/MEDICAL SUPPLY INFORMATION					
Drug Name or Medical Supply	Strength	NDC No.	Lot No.	Exp. Date	Qty