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**Iowa Prescription Drug Donation Program  
 Individual Donation Record**

**Medication/Medical Supply Information**

1.	Medication/Medical Supply		Manufacturer/NDC #	
	Drug Strength & Dosage Form	Expiration Date	Quantity	Lot # (if available)

2.	Medication/Medical Supply		Manufacturer/NDC #	
	Drug Strength & Dosage Form	Expiration Date	Quantity	Lot # (if available)

3.	Medication/Medical Supply		Manufacturer/NDC #	
	Drug Strength & Dosage Form	Expiration Date	Quantity	Lot # (if available)

Additional Items Should Be Listed on the Back of This Form

**Donor Information & Certification**

Donor — Name and Address (print)
Donor's Representative — Name and Address (print)

I **certify** that the medications or medical supplies listed on this form were stored as recommended by the manufacturer and have not been tampered with:

Signature — Donor or Donor's Representative	Date Donated
Signature — Donation Program Representative	Date

Completion of this form meets the requirements of Iowa Administrative Code 641 — 109.4(a, b, c, h) and 109.4 (5a, b, c) for donating drugs and supplies.

Questions about completing this form may be directed to the Iowa Prescription Drug Corporation toll-free at 1-866-282-5817.