



OKLAHOMA STATE BOARD OF PHARMACY
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APPLICATION FOR DONATION OF UNUSED PRESCRIPTION DRUGS
(for Oklahoma Assisted Living Centers)

Date: _____ (Please Print Clearly)

Name of Assisted Living Center:

Address of Assisted Living Center:

Phone Number: _____

County: _____

Name of **Consultant Pharmacist** (please print):

Name of **Director of Nursing** (please print):

Name of **Person in Charge of Medications** (please print):

Medication room?	Yes ___	No ___
Locked cabinet?	Yes ___	No ___
Locked cart?	Yes ___	No ___
All prescription drugs kept under control of health care professional?	Yes ___	No ___
All prescription drugs kept in sanitary & temperature controlled conditions?	Yes ___	No ___
All prescription drugs kept in secure conditions (locked when not in use)?	Yes ___	No ___
All prescription drugs ordered by health care professional?	Yes ___	No ___

Type of Drugs Anticipated for Donation: **Unit Dose** ___ **Unused Injectables** ___ **Other** ___

If other was indicated, please explain: _____

Pharmacy(s) intended for donation (name and address):

(1) _____

(2) _____

(3) _____

Name and Title of **Person Completing Application** (please print):

Name _____ Title _____

Consultant Pharmacist Printed Name and Signature:

Name _____ Signature _____