Florida Department of Business & Professional Regulation

DONATION AND DESTRUCTION RECORD

DRUGS, DEVICES, AND COSMETICS PROGRAM
Cancer Drug Donation Program
1940 N. Monroe Street, Suite 26A
Tallahassee, FL 32399-0783
Phone: (850) 717.1802
Email: CDDP@dbpr.state.fl.us
Fax: (850) 414.8240

Completion of this form meets the requirements under 61N-1.026, Florida Administrative Code (F.A.C.) for donating drugs and supplies and for the destruction of drugs or supplies under the Cancer Drug Donation Program. This form must be maintained for at least three years. Questions about completing this form may be directed to (850) 717.1802.

DONATION RECORD

Any of the following persons or entities may donate legally obtained cancer drugs or supplies to the Cancer Drug Donation Program if the drugs and supplies meet the requirements in 61N-1.026(6), F.A.C., as determined by a pharmacist who is employed by or under contract with a Cancer Drug Donation Program participant facility: A patient or patient's representative whose cancer drugs or supplies have been maintained within a closed drug delivery system, such as health care facilities, nursing homes, hospices, or hospitals; a physician licensed under chapter 458, or 459, Florida Statutes, who receives cancer drugs or supplies directly from a drug manufacturer, drug wholesaler, or pharmacy; a pharmacy; a drug manufacturer; a medical device manufacturer or supplier; or a wholesaler of drugs or supplies.

Name – Donor _____ Date Donated _____

Name – Institutional Class II Hospital Pharmacy Receiving Donation _____

Name – Medication or Medical Supply _____

Medication Strength _____ Expiration Date _____ Lot Number _____ Quantity _____

I certify that the above named drug or supply was stored as recommended by the manufacturer and that the drug or supply has never been opened, used or tampered with, adulterated or misbranded.

SIGNATURE – Donor or Designee _____ Date Signed _____

Name – Pharmacist Accepting Donation _____ License No. _____

SIGNATURE – Pharmacist Accepting Donation _____ Date Signed _____

DESTRUCTION OR DISPOSAL INFORMATION

Name – Medication or Medical Supply _____

Medication Strength _____ Expiration Date _____ Lot Number _____ Quantity _____

Name – Person or Firm Destroying or Disposing of Drug or Medical Supply _____ **SIGNATURE – Authorized Agent** _____ Date Destroyed _____