



NOTICE OF PARTICIPATION OR WITHDRAWAL

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 notification requirement for participation in, or withdrawal from, the Cancer Drug Donation Program under 61N-1.026, Florida Administrative Code (F.A.C.). Complete and submit this form to the address or fax number provided above. Questions about completing this form may be directed to (850) 717-1802. This form must be maintained for at least three years.

NOTICE OF PARTICIPATION INSTITUTIONAL CLASS II HOSPITAL PHARMACY

Only an Institutional Class II hospital pharmacy, permitted under chapter 465, Florida Statutes that accepts, stores and dispenses donated drugs and supplies may participate in the cancer drug donation program.

Name – Institutional Class II Hospital Pharmacy

Permit No.

Street Address

City

State

Zip Code

Telephone Number

Each participating pharmacy must provide a pharmacist contact or other contact person as determined by the pharmacist who is employed by or under contract with the pharmacy.

Name – Pharmacist or Designee

License No.

Telephone Number

I certify that the above named facility is licensed in the State of Florida and is in compliance with all State and Federal law and administrative rules. I further certify that the facility named above meets the requirements set forth under 61N-1.026(3)(a), F.A.C.

SIGNATURE – Pharmacist or Designee

Date Signed

NOTICE OF WITHDRAWAL INSTITUTIONAL CLASS II HOSPITAL PHARMACY
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A Class II Institution Pharmacy may withdraw from participation in the program upon at least 10 days written notification to the Cancer Drug Donation Program.

Name – Institutional Class II Hospital Pharmacy

Permit No.

Street Address

City

State

Zip Code

Telephone Number

As of _____ (date) the Institutional Class II hospital pharmacy identified above, will no longer participate in the Cancer Drug Donation Program.

SIGNATURE – Pharmacist or Designee

Date Signed