DRUGS RETURNED TO CENTRAL PHARMACY

NAME OF ORGANIZATION: _____
ADDRESS:_____
CITY: _____
PROGRAM: _____

Inventory Budget #'s	ITEM (Be Specific)	LOT #	EXP. DATE	QTY FULL	PARTIALS	CREDIT PHR USE ONLY YES = S NO = D

FOR VACCINES, REPORT VIALS NOT DOSES

COMPLETED BY: _____ **DATE: ____/_____/_____**

REV. 05/26/2000