

Nevada State Board of Pharmacy

431 W. Plumb Lane, Reno NV 89509

775-859-1440 or Toll Free 1-800-364-2081 Fax 775-859-1444

Email: pharmacy@pharmacy.nv.gov Website: <http://www.bop.nv.gov>

CANCER DRUG DONATION PROGRAM

PATIENT PARTICIPATION FORM

Completion of this form meets the requirements of NRS Chapter 457 for the Cancer Drug Donation Program for donating drugs.

NOTICE OF PARTICIPATION

Name- Recipient (print or type)	Date of Birth
Address	
City, State Zip Code	Telephone Number

I certify that I am a Nevada Resident and that I understand that the medication I am receiving has been donated and has potentially been stored in a non-controlled environment. I understand that the health care provider, pharmacy, pharmacist, and manufacturer cannot be held liable for problems with this medication that has been accepted for donation and dispensed in good faith.

SIGNATURE -Recipient	Date Signed
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MEDICATION DISPENSING INFORMATION

Name of Medication		
Strength	Expiration Date/Lot Number	Quantity Received

NOTE: The pharmacy may place a copy of the label on this form in lieu of entering the medication dispensing information.

SIGNATURE - Pharmacist	Date Signed
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NOTE- please keep this record with the DRUG DONATION, TRANSFER, AND DESTRUCTION FORM

Return completed form to address listed in header.