OKLAHOMA STATE BOARD OF PHARMACY
2920 N Lincoln Blvd, Ste A, Oklahoma City, OK 73105
Phone: 405-521-3815 / Fax: 405-900-8365
www.pharmacy.ok.gov
e-mail: pharmacy@pharmacy.ok.gov

APPLICATION FOR DONATION OF UNUSED PRESCRIPTION DRUGS

[for Oklahoma Assisted Living Centers & Residential Care Homes]

Date: _____ (Please Print Clearly)

Name of Assisted Living Center *[as licensed by the Oklahoma Health Department]*:

_____ ***License #:*** _____

Address of Assisted Living Center:

_____

_____

Phone Number: _____ ***County:*** _____

Facility donating the prescription drugs is an Oklahoma licensed Nursing home or approved Oklahoma licensed Assisted Living Center (ALC) in good standing with the Oklahoma State Department of Health (OSDH)? Yes____ No____

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

_____OK License #: _____

Name and Email of ***Director of Nursing*** *(please print)*: License #:

_____

Name, Email and Title of ***Licensed Person in Charge of Medications*** *(please print)*: License #:

_____

_____

Medication room?	YES	NO
Locked cabinet?	YES	NO
Locked cart?.....	YES	NO
All prescription drugs kept under control of licensed 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 licensed 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: *[Must be a qualifying pharmacy as defined by 367.3 of Pharmacy Statutes]*

1. Name: _____ City: _____ OK License #: _____

2. Name: _____ City: _____ OK License #: _____

3. Name: _____ City: _____ OK License #: _____

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

Name_____

Email _____

Title_____

I swear and affirm under penalty pursuant to Title 21 O.S. 491 and/or discipline by the Board of Pharmacy under the pharmacy laws and rules of the State of Oklahoma, that all information I have supplied herein is true and complete to the best of my knowledge and belief. I agree to comply with the Oklahoma Pharmacy Act and Rules.

Consultant Pharmacist Printed Name and Signature:

Name_____ Signature_____ License #:_____

FOR OSBP OFFICE USE ONLY:

Approved _____ **Denied** _____ **Date:** _____

Approval letter will be emailed to consultant pharmacist at the email address on file