



South Dakota Board of Pharmacy

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**DONATED PRESCRIPTION DRUG AND MEDICAL SUPPLY REDISPENSING PROGRAM
DISPENSING/RECIPIENT RECORD**

- Completion of this form meets the requirements of SD Board of Pharmacy: ARSD 20:51:35:06 Donated Prescription Drug and Medical Supply Redispensing Program
- Questions about completion of this form may be directed to 605-362-2737.

Name – Recipient	Date Dispersed
_____	_____

Processing Fee (if applicable) Not to Exceed \$25.00: \$ _____

Name – Medication

Medication Strength	Expiration Date	Quantity Dispersed
_____	_____	_____

NDC	Lot Number
_____	_____

- I understand that the medication or supply I am receiving has been donated and has potentially been stored in a non-controlled environment.
- I understand that the pharmacy, pharmacist, and manufacturer cannot be held liable for problems with this medication that has been accepted for donation and dispensed in good faith.
- I understand that the pharmacy is providing the medication free-of-charge and that I will not be charged, nor will my insurance be charged any amount for this specific fill; however, I may be charged a processing or mailing fee pursuant to ARSD 20:51:35:11.
- I understand that this is a one-time transaction dependent on the supply of donated inventory, that there is no guarantee or expectation by the pharmacy to provide a subsequent fill free of charge.
- I understand that I may request a copy of this form for my personal records.

SIGNATURE – Recipient	Date Signed
_____	_____

SIGNATURE – Dispensing Pharmacist	Date Signed
_____	_____