OREGON CHARITABLE PHARMACY

Recipient (Patient) Form

Name of Charitable Pharmacy Dispensing Donated Medication:

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Name, and phone number if available, of Recipient:

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Address of Recipient:

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City State Zip

Name, quantity, prescription number, lot # and expiration date of drugs received:

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I understand that the above named medication(s) that I am receiving has been donated, may have been previously dispensed and has potentially been stored in an uncontrolled environment.

Further, I attest that:

1. **<u>I was notified of the following:</u>**
   a. The prescription drug was donated to the program.
   b. A visual inspection was conducted by a pharmacist to ensure that the drug has not expired, been adulterated or misbranded, and is in its original, sealed packaging.
   c. A pharmacist has determined that the drug is safe to distribute based on the accuracy of the Donor's Form and the visual inspection by the pharmacist.
   d. Participants in the program are immune from liability as provided in ORS 689.780

2. <u>I am qualified to receive the drug(s)</u> as I am an Oregon resident and am either underinsured or do not have adequate health insurance coverage for the prescription drug requested, or I am enrolled in a program of public assistance.

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Signature of recipient **Date**