



Medication Repository Program Combined Recipient Form

Completion of this form meets the requirements of Minnesota Statute 151.555 for:

- Obtaining attestation of eligibility to receive donated drugs or medical supplies.
- Dispensing or administering drugs and medical supplies to eligible recipients.

This form must be kept on file for at least two years and faxed within ten days to RoundtableRx at 866-254-9105.

For questions, contact the Minnesota Medication Repository Program:
Phone: 612-584-4647 | Fax: 866-254-9105 | Email: info@roundtablrx.org

Recipient Information

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|----------------------|--|
| Recipient Name: | |
| Date of Birth: | |
| Phone Number: | |
| Address: | |
| Date of Application: | |

Drug / Medical Supply Information

| Name, Strength, Form (incl. NDC if known) | Expiration Date | Lot Number | Quantity |
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Eligibility Attestation

By signing this form, I attest that:

- I am a resident of Minnesota.
- I have no prescription drug coverage, or I am underinsured.
- I acknowledge that the drugs or medical supplies I receive through this program may have been donated and may have been previously dispensed.
- I consent to waive the child-resistant packaging requirements of the federal Poison Prevention Packaging Act.

Certification

I understand that: - A pharmacist or practitioner has visually inspected the donated items to confirm they have not expired, have not been adulterated or misbranded, and were donated in original manufacturer unopened packaging or sealed unit-dose packaging. - The pharmacist, practitioner, repository, Board of Pharmacy, or any other program participant cannot guarantee the safety of the donated drugs or supplies. - The pharmacist or practitioner determined the items are safe to dispense or administer based on the donor form and required visual inspection.

Recipient Signature: _____ Date: _____

Repository Review (For Staff Use Only MUST COMPLETE)

Minnesota Resident: Yes No

Uninsured: Yes No

Underinsured: Yes No

Recipient eligible: Yes No

Reviewed by (print): _____

Repository Name: _____