

PRESCRIPTION DRUG INVENTORY

FACILITY: _____

PAGE: _____ OF _____

ADDRESS: _____ (see cover page) CITY: _____ (see cover page) COUNTY: _____ (see cover page)

_____ DANGEROUS DRUGS _____ CONTROLLED SUBSTANCES

DATE OF DESTRUCTION: _____

Refill sticker	Qty	Refill sticker	Qty
Date Dispensed Name of Pharmacy Drug Name and Strength RX#		Date Dispensed Name of Pharmacy Drug Name and Strength RX#	
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Witness initials _____/_____/_____