PRESCRIPTION DRUG REPOSITORY PROGRAM

RECIPIENT FORM

Date:_____

Name of recipient:_____

Address:_____

_____

Phone Number:_____

Email address (optional):_____

List of prescription drugs or medical supplies received:_____

_____

_____

_____

_____

_____

_____

The recipient understands that:

The recipient is receiving prescription drugs or medical supplies that have been donated to the program, and

Entities involved in the program have immunity from liability in accordance with Health-General Article, §15-607, Annotated Code of Maryland.

_____

Signature of Recipient