MARYLAND
Department of Health
Larry Hogan, Governor ● Boyd Rutherford, Lt. Governor ● Robert R. Neall, Secretary

MARYLAND BOARD OF PHARMACY
4201 Patterson Avenue, Baltimore, Maryland 21215-2299
Kevin M. Morgan, Board President ● Deena Speights-Napata, Executive Director

REPOSITORY/DROP OFF SITE INSPECTION FORM

Corporate Pharmacy Name ____________________________________________________________
Pharmacy or Healthcare Facility Name – Doing Business as (d/b/a) or Trade Name__________
______________________________________________________________________________
Street Address _____________________________________________________________________
Business Telephone Number __________________ Business Fax Number ________________________
Inspection Date: ________________Arrival Time_______________ Departure Time_____________
Type of Inspection: Annual Follow-up Previous Date: ______________________________________
Name of Inspector: __________________________________________________________________

A. GENERAL INFORMATION- Drop Off Sites

Maryland Pharmacy Permit Number ___________________ Expiration Date: __________________
CDS Registration Number ____________________________ Expiration Date: __________________
DEA Registration Number ____________________________ Expiration Date: __________________

1. Yes No
□  □ Inspect for ineligible drugs including prescription drugs or medical supplies that may not
be accepted by the Program, and the pharmacist or other health care provider approved by the
Office of Health Care Quality inspects donated items prior to acceptance into the Program.

Comments:___________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

2. Yes No
□  □ The permit holder has, and is using proper forms used to donate a prescription drug or
medical supply containing the following statements:

Yes No
□  □ That the donor is the owner, or the owner's representative, of the prescription drug or
medical supply;
□  □ That the donor intends to voluntarily donate the prescription drug or medical
supply to the Program and
□  □ Contains the date and signature of the donor or the donor's representative.

Comments:___________________________________________________________________________
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_____________________________________________________________________________________
_____________________________________________________________________________________
3. Yes No
☐ ☐ The permit holder maintains a secure dropbox/sealed bag for donated medications that may only be opened by the pharmacist.

Comments:___________________________________________________________________________
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_____________________________________________________________________________________
_____________________________________________________________________________________  

4. Yes No
☐ ☐ The permit holder maintains records required by this Program for a minimum of 5 years including: inventory, donor forms.

Comments:___________________________________________________________________________
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_____________________________________________________________________________________
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B. GENERAL INFORMATION- Repository

1. Yes No
☐ ☐ Inspect for ineligible drugs including prescription drugs or medical supplies that may not be accepted by the Program, and the pharmacist inspects donated items prior to acceptance into the Program.

Comments:___________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
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2. Yes No
☐ ☐ The permit holder has, and is using proper forms used to donate a prescription drug or medical supply containing the following statements:

Yes No
☐ ☐ That the donor is the owner, or the owner's representative, of the prescription drug or medical supply;
☐ ☐ That the donor intends to voluntarily donate the prescription drug or medical supply to the Program and
☐ ☐ Contains the date and signature of the donor or the donor's representative.

Comments:___________________________________________________________________________
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_____________________________________________________________________________________
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3. Yes No □ □ The pharmacist inspects all donated items to determine if the item is acceptable for re-dispensing or shall be destroyed.

4. Yes No □ □ The pharmacist or technician obliterates from the labels of donated prescription drugs or medical supplies any patient specific information prior to placing into Program inventory.

Comments:___________________________________________________________________________
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5. Yes No □ □ The permit holder maintains a separate inventory for all donated Program drugs and supplies from the regular pharmacy inventory.

Comments:___________________________________________________________________________
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6. Yes No □ □ Inspect for procedure for the re-dispensing of donated prescription drugs or medical supplies in compliance with applicable federal and State laws and regulations for dispensing prescription drugs or medical supplies.

Comments:___________________________________________________________________________
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____________________________________________________________________________________

7. Yes No □ □ Inspect procedures for shipping donated prescription drugs or medical supplies to recipients of this Program.

Comments:___________________________________________________________________________
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8. Yes No
   □ □ There are written policies and procedures for disposing of donated prescription drugs or medical supplies that do not meet the requirements of Regulation .02 of this chapter in compliance with applicable State and federal laws and regulations for disposing of prescription drugs or medical supplies.
   Comments:___________________________________________________________________________
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   _________________________________________________________________________________
   _________________________________________________________________________________

9. Yes No
   □ □ The permit holder maintains records required by this Program for a minimum of 5 years including: inventory, donor forms, dispensing records, destruction information.
   Comments:___________________________________________________________________________
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   _________________________________________________________________________________
   _________________________________________________________________________________

10. Yes no
    □ □ Are separate inventories being maintained?
Inspectors Comments:

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Inspector Signature

Pharmacist Name ((Print): ___________________________ Date:______________

Signature: ________________________________________________