Record of Local Destruction of Post-Consumer Returns Containing Narcotics, Controlled Drugs or Targeted Substances

Pharmacy Name: _____

Pharmacy Address:

_____ _____
Street Address P.O. Box (if applicable)

_____ _____ _____
City/Town Province Postal Code

Container Unique Identifier

Details on Method of Destruction Used: _____

_____

_____

_____

☐ By signing below, both parties certify that the substances noted above were altered or denatured to such an extent as to render consumption impossible or improbable.

Pharmacist-in-Charge:

_____ _____
Name Registration #

_____ _____
Signature Date of Destruction

Witness:

_____ _____
Name Profession

_____ _____
Signature Date of Destruction

Use Additional Pages as Necessary