Wyoming Medication Donation Program
Wyoming Department of Health, Pharmacy Services
2508 E. Fox Farm Road, Suite 2A
Cheyenne, WY 82007
Ph: (307)-635-1297 OR (855)-257-5041

Donor Record

Completion of this form is pursuant to the Drug Donation Program Act, Wyoming House of Representatives Bill No. 0194 and the Wyoming Administrative Procedures Act. Questions about completion of this form may be directed to 307-635-1297.

Donor Name: _____ Date of Donation:_____

Donor Address:_____ City/State/Zip:_____

Donation Site Name:_____

Medication Name & Strength *Must be completed*	Quantity (# of Bottles, sample boxes, etc.)

Initials of Staff accepting donation:_____

1) Why are you donating this medication?

___ Didn't use it all
__ Side effects
___ Doctor told me to stop/ changed my medication
___ Found something cheaper
___ Wanted to try the newer version
___ Owner of the medications passed away
___ Wanted to dispose of properly
Other: _____

2) Why do you keep unused medications?

___ I don't
___ In case I need them later
___ I didn't know how to dispose of them
___ In case someone I know needs them
Other:_____

I certify that the above-named medications were stored as recommended by the manufacturer and have not been tampered with.

_____ _____
Donor Signature Date

Section 6. Immunity. Any person or entity, which exercises reasonable care in donating, accepting, distributing/dispensing medications under the Drug Donation Program Act or rules and regulations adopted and promulgated under this act shall be immune from civil or criminal liability or professional disciplinary action of any kind for any related injury, death or loss.

Donor Record- Continued

Please staple pages together

Donor Name: _____ Date of Donation:_____

Medication Name & Strength (*Must be completed*- No Narcotics or refrigerated drugs can be accepted, please ask for disposal information)	Quantity (# of Bottles, sample boxes, etc.)

Initials of Staff accepting donation:_____