STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
https://www.tn.gov/health/health-program-areas/health-professional-boards/pharmacy-board.html

PRESCRIPTION DRUG DONATION RESPOSITORY PROGRAM INTAKE COLLECTION

Intake Information			
Recipient Name:		Date:	
Recipient Address:	City:	State:	Zip Code:
Recipient Telephone Number: ( )		Recipient Email Address (Optional):	

Affidavit and Release

I, ____, being duly sworn and identified as the
(Print Name)
person referred to on this form, or authorize representative of the person identified, attest to the following:

- I am a resident of the State of Tennessee.
- My income is below 200 percent (200%) of the Federal Poverty Level (FPL).
- I am uninsured and have no prescription coverage for the prescribed drugs.
- I understand that the drugs may have been donated.
- I consent to a waiver of the requirement for child resistant packaging of the Poison Prevention Packaging Act (16 C.F.R. §§ 1700-1702).

______________________________________ ______________________________
Signature of Recipient Date

Pursuant to Official Compilation of Rules and Regulation of the State of Tennessee 1140-17-.07 (2)(b) and (3). The intake collection form shall include an identification card to be given to the recipient for continued used for one year or until the new federal poverty guidelines have been published for all prescriptions and supplies.