Receipt of Controlled Substances

DATE: __________________

TO: __________________

FROM: PHARMACY

This form is to assure DOC Pharmacy that the facility named above actually received the controlled substance medication requested.

Name of C.S. Drug Received:

1. ______________________ Quantity: ________

2. ______________________ Quantity: ________

3. ______________________ Quantity: ________

4. ______________________ Quantity: ________

5. ______________________ Quantity: ________

Signature: ________________________________

After completing this form please fax it to (907) 269-7335.

THANK YOU