Pharmaceutical Excellence

KENYA PHARMACEUTICAL ASSOCIATION CENTRAL BRANCH

PHARMACEUTICAL WASTE DISPOSAL APPLICATION FORM

MEMBER NAME:_____ ENROLLMENT NUMBER:_____

PREMISE NAME:_____ ID NUMBER:_____

MOBILE NUMBER:_____ EMAIL:_____

Product Name	API	Dosage Form	Unit of Issue	Quantity	Weight (Kgs)	Reason for Disposal	Proposed Method of Disposal

Consent

I, the undersigned, hereby confirm that the above information is true and accurate to the best of my knowledge and authorize the disposal of the listed pharmaceutical products as per the proposed method.

Signature: _____ Date: _____

Note: Fill in triplicate