Pharmacy Requesting Off-Site Record Storage

Pharmacy: _____ Permit #: _____
Address: _____
_____
_____
Phone: _____ Fax: _____ Email: _____

Records to be moved off-site:

Prescriptions_____ Dispensing Reports _____
Invoices _____ Inventory Records_____
Other Records (specify): _____

Age of Records: Greater than _____ years.

Storage location:
Facility name: _____
Address: _____
_____
_____
Phone: _____

Is the storage location climate controlled and protected from fire, water, or other potential damage? Yes:__ No:___

How will the storage location be secured? _____

Name(s) and titles of those with access (i.e. key) to storage location:
_____
_____
_____
_____
_____

Name of Person Making Request: _____
Title: _____
Date: _____