Peninsulas EMS Council, Inc.

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Medication Box Exchange Form

MUST PRINT ALL FIELDS **Box #** ________________

Kit Exchange:				
Date Time				
EMS Agency: Name				
AIC Provider Name or Employee #:				
PPCR or Incident #:				
Narcotics Accounted For By EMS & Pharmacy/ED				
Pharmacy Restocking: Date				
Pharmacy Hospital: Name				
Hosp. Rep. First Initial Last Name				
1st Drug Expiration: Name & Date				
Last Exterior Seal #:				
New Exterior Seal #:				
Redistributed To (Agency Name)				