**AfroHealth Inc. – Medication Donation Form**

**Donor Information**

* **Full Name:**
* **Organization (if applicable):**
* **Phone Number:**
* **Email Address:**
* **Mailing Address:**

**Medication Donation Details**

*(You can list multiple medications below.)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Strength (e.g., 500mg)** | **Quantity** | **Expiration Date** | **Seal Intact? (Yes/No)** | **Notes (short-dated, oncology drug, opened bottle, etc.)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |

**Need to add more?** You can attach an additional sheet or use the Notes box below.

**General Questions**

* **Are any medications short-dated (expiring in less than 6 months)?**
	+ ( ) Yes
	+ ( ) No
* **Are any medications opened (only for expensive drugs like oncology meds)?**
	+ ( ) Yes
	+ ( ) No
* **Do you have any special handling instructions?**

**Consent & Acknowledgment**

☐ I confirm all medications are non-expired (unless otherwise approved) and sealed unless noted.
☐ I confirm no narcotics or controlled substances are included.
☐ I agree to AfroHealth Inc.'s Terms and Conditions and Privacy Policy.

**Electronic Signature (Type Full Name):**
**Date:** (Date Picker)