PRESCRIPTION DRUG REPOSITORY PROGRAM
LOCAL REPOSITORY - NOTICE OF PARTICIPATION OR WITHDRAWAL

- Completion of this form meets the notification requirement for participation in, or withdrawal from, the Prescription Drug Repository Program under Minnesota Statute Section 151.555. Complete and submit this form to the Minnesota Medication Repository Program (RoundtableRx), the Central Repository under contract with the Board, at the following address. (Do not submit this form to the Board of Pharmacy). Questions about completing this form may be directed to RoundtableRx at 612-584-4647. This form must be maintained for at least five years.

RoundtableRx
Minnesota Medication Repository Program
2112 Broadway NE St
Minneapolis Minnesota 55413
OR EMAIL TO
info@roundtablerx.org
Secure Fax: (866) 254-9105

NOTICE OF PARTICIPATION - PHARMACY OR OTHER HEALTH CARE FACILTY

A pharmacy or other eligible health facility may participate in the prescription drug repository program by agreeing to accept, store, and dispense donated drugs and medical supplies. Participants must agree to comply with all applicable federal and state laws, rules, and regulations pertaining to the drug repository program, drug storage, and dispensing. The facility must also agree to maintain in good standing any required state license or registration that may apply to the facility. Participation is voluntary - a participant can agree to participate or to withdraw from the program at any time by submitting this form to the Central Repository. A facility must not act as a local repository until it receives approval from the Central Repository.

Name – Pharmacy or Health Care Facility	Telephone Number	
Address		
City	State	Zip Code
Name – Pharmacist or Practitioner Responsible for Dispensing	Telephone Number	

I certify that the above-named facility is licensed in the State of Minnesota (if required to be licensed) and is in compliance with all applicable federal, state, and local statutes, rules and ordinances that apply to the facility. I agree that the facility meets the eligibility requirements under, and agrees to comply with, Minn. Stats. Section 151.55.

SIGNATURE – Pharmacist or Practioner Responsible for Dispensing	Facility/Practitioner License Number	Date Signed

NOTICE OF WITHDRAWAL - PHARMACY OR OTHER HEALTH CARE FACILTY

Name – Pharmacy or Health Care Facility	Telephone Number	
Address		
City	State	Zip Code

As of_____, the pharmacy or health care facility identified above, will no longer be participating in the Prescription
(Date)
Drug Repository Program.

SIGNATURE – Pharmacist or Practitioner Responsible for Dispensing	Date Signed