# Methoxyflurane for Disposal Form

Complete this form and have it signed by a pharmacist at the receiving pharmacy.

Division or group sending methoxyflurane to local pharmacy for disposal:

_____

Name of store that methoxyflurane has been taken from:

_____

If your division/group has more than one store of methoxyflurane, please record which store these units have been removed from (E.g.: Disaster Kit 1). If your division only has one store of methoxyflurane just write *"Main Store"*.

Name and address of local pharmacy that will be receiving methoxyflurane for disposal:

_____

Date removed from store: _____

Date given to pharmacy: _____

Name of member delivering: _____

Position of member delivering: _____

Name of Pharmacist receiving: _____

**Number of methoxyflurane removed for disposal:** _____

St John (NSW) Member Signature: Date:

_____ _____

By singing above, the St John (NSW) member declares that at the time of removal from the store/safe, the number of units of methoxyflurane removed matches the number recorded on this form and in the Register of Restricted Medications

Pharmacist to Complete

**Number of units received:** _____

Pharmacist Signature Date

_____ _____

By signing above, the pharmacist confirms that the quantity delivered for disposal is congruent with the quantity recorded on this form only. There is no requirement for the pharmacist to see the Register of Restricted Medications.

Form to be retained at a local level with the Register of Restricted Medications for review upon audit