Micro Labs Limited

Clobazam Tablets, 10 mg

Retail Level

February 15, 2024

VOLUNTARY RECALL RESPONSE FORM

Date Form Completed _____

Please fill out this form completely, by doing so this will acknowledge that you have read and understand the recall notice and have taken the appropriate action. Once complete please return your response form by any one of these means to Inmar, Attn: Recall Team: EMAIL: RxRecalls@Inmar.com FAX: 1-817-868-5362

This Response Form is for (Check One)	☐ **Direct Customer (Purchased Directly from MANUFACTURER)** ☐ **Non-Direct Customer**
Customer/Store Name:	
*DEA #: ***DEA # is required in order to process your form***	Debit Memo # (If Applicable)
Address:	City/State/Zip
Contact Name (please print):	Email Address: Telephone #: Fax #:

Please mark your answer - I have checked my stock and:

☐ I ***do*** have stock of the recalled item(s) **(Complete Below Table)** **OR** ☐ I ***do not*** have stock of the recalled item(s).

Direct Customers

Does your response include **all** your DC locations? ☐ YES ☐ NO

Have you notified your customers of this recall down to the appropriate level? ☐ YES ☐ NO

Non-Direct Customers

Name of Wholesaler/Distributor and address the product(s) in this recall were purchased from (Please include DEA):

☐ ***I have quarantined and listed in the table below the quantity of recall units I will be returning to Inmar.***

If additional space is needed please make copies of this form

NDC	Lot #	Exp. Date	Qty. Sealed to be returned	Qty. Partial Units to be returned (Tablet Count)

Any Adverse Events Associated with this recalled product? ☐ No ☐ Yes (if yes please attach additional sheet and explain)

Please indicate the number of shipping labels that you need to return the recalled product(s): _____