



RECALL STOCK RESPONSE FORM
RECALL of Tizanidine Tablets USP 4mg
(Retail Level)
01/02/2024

Please fill out this form completely. By doing so, this will acknowledge that you have read and understand the recall instructions and have taken the appropriate action. **If this form is not filled out correctly and in its entirety, you may not be eligible for credit.**

Company Name _____ DEA # _____

Debit Memo # _____ Original Invoice # _____

**DEA # and Debit Memo # is required, without it, processing of your form will be delayed.*

Address _____

City _____ State _____ Zip _____

Contact Name (please print) _____ Telephone # _____

Contact Signature _____ Date _____

I have checked my stock and:

_____ Do not have any stock of the recalled **items**.

OR

I have quarantined and listed in the box below the quantity of recalled units and will be returning to Inmar. Upon receipt of this Response Form, Inmar, will issue return authorization label(s) and will need _____ # of box labels.

Product Name	Lot Number	NDC Number	Quantity Returned
Tizanidine Tablets USP, 4mg	T2304007	55111-180-15	

Wholesalers and Distributors only

☐ I have identified my customers that were shipped or may have been shipped this product. Attached is a list of customers with their contact details who received/may have received this product.

Any adverse events associated with recalled product? ☐ Yes ☐ No

If yes, please explain: _____



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If you did not purchase the product directly from the Manufacturer, please complete the below section.

Purchased from: Wholesaler Name _____ DEA # _____

City _____ State _____

If you have any questions regarding this form or product return, please contact Inmar at 855-201-3861 office hours 9am to 5pm (EST) Monday through Friday.

Please fax this form to: 1-817-868-5362 or E-mail: RXrecalls@inmar.com