RECALL STOCK RESPONSE FORM

RECALL of Tizanidine HCl Tablets
(Retail Level)
09/04/2018

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.

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 I will be returning to Inmar. Upon receipt of this Response Form, Inmar, will issue return authorization label(s) and will need_____ # of box labels

Item Description	NDC	Lot	Quantity returned
Tizanidine HCl Tablets 2mg, 150 count	55111-179-15	T800304	

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.

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 1-800-967-5952 Office hours 9am to 5pm (EST) Monday through Friday.

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