RECALL STOCK RESPONSE FORM

Ceftriaxone USP 500 mg per Vial
VOLUNTARY RECALL 09/19/2016

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.

Customer Name _____ DEA #_____

DEA # is required, if not provide the 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

Have quarantined and listed in the box below the qty of recalled units I will be returning to Inmar, as soon as possible. Upon receipt of this Response Form, Inmar, will issue return authorization label(s) Please indicate the # of needed box labels _____.

Item Description	NDC	Lot #	Qty returning
Ceftriaxone for Injection, USP 500 mg per Vial	**64679-702-02**	**CP10027 (Vial)**	

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 8am to 5pm EST Mon thru Fri.

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