Qualitest
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Qualitest
an endo international company

RECALL RESPONSE FORM

VOLUNTARY RECALL – RETAIL LEVEL

PRODUCT DESCRIPTION	NDC NUMBER	LOT #	EXP DATE	Units Returning
Promethazine VC With Codeine Syrup , One Pint (473 mL)	0603-1588-58	0000002247	3/16	
Promethazine VC With Codeine Syrup , One Pint (473 mL)	0603-1588-58	L073D14B	7/15	
Promethazine VC With Codeine Syrup , One Pint (473 mL)	0603-1588-58	L063B14A	5/15	
Promethazine VC With Codeine Syrup , 4 ounces (118 mL)	0603-1588-54	L073D14A	7/15	

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.

Store Name _____ DEA #_____

**DEA # is required, if not provided the processing of your form will be delayed.*

Address_____

City_____ State_____ Zip_____

Contact Name (please print)_____ Telephone #_____

Contact Signature _____ Date_____

I have notified my customers that were sold/shipped affected recalled product

Circle one: YES or NO-I did not sell/ship affected product.

I have checked my stock and:

_____Do not have any stock of the recalled products listed above.

OR

Have quarantined and listed in the box above the quantity of units the above product lots. I will be returning to CLS MedTurn, an Inmar company, as soon as possible. Upon receipt of this Response Form, CLS MedTurn, an Inmar company, will issue return authorization labels _____(please indicate the # of box labels needed.)

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

Purchased From: Name _____ DEA #_____

Address_____

City_____ State_____ Zip_____

If you have any questions regarding this form or product return please contact CLS MedTurn, an Inmar company at 1-800-967-5952

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