COUNTY OF MARIN

Dispensing Partner Inventory Control Form

MARIN HEALTH & HUMAN SERVICES
Health, Well-being & Safety

Drug: _____ Lot#:_____
Quantity: _____ Date:_____

Date	Time	Quantity		Lot Number (Do not include more than one lot number on a line))	Name of Person Receiving or Returning Medications	Initials of Person Receiving or Returning Medications	Notes:
		Out	In				

Total Quantity: Out:_____ **In:**_____