Partners in Recovery

MEDICATION DISPOSAL LOG

Date of Disposal	*Medication*	Quantity Disposed of	Method of Disposal	Staff Name, Signature, and Professional Credential or Job Title	Staff Name, Signature, and Professional Credential or Job Title

Medication Disposal Log to be filed in the Recipient's medical record for Assistance in the Self-Administration of Medication

Service Recipient's Name _____

CIS ID # _____