TITLE OF FORM:	
Number of pages:	Procedure Number
Prepared by: Date: Designation	Approved by: Date: Designation

Waste Disposal Form

[NAME] Health Facility

Disposal Form No._____

Item	Product Description	Unit Pack	Reason for Disposal	Disposal Method	Quantity	Unit Cost	Total Value	Remarks
1	Chloramphenicol eye drops	10ml	Expired 11/04	Sewer	50	5.00	250.00	
2	Vit. B Co syrup	100 ml	Broken bottles	Sewer	12	10.00	120.00	Slipped through unsealed carton bottom
3	Penicillin tabs	1000	Expired	Encapsulation	8	20.00	160.00	Antibiotic, do not destroy by landfill
Total on this form							370.00	

Store keeper name: _____ Signature: _____ Date: _____

Head of Accounting: _____ Signature: _____ Date: _____

Head of Facility: _____ Signature: _____ Date: _____

Disposing Officer: _____ Signature: _____ Date Disposed: _____

Review Date:					
Date Reviewed:					
Signature:					