# Record of Local Destruction of Post-Consumer Returns Containing Narcotics, Controlled Drugs or Targeted Substances

**Pharmacy Name:** _____

**Pharmacy Address:**

_____ Street Address

_____ P.O. Box (if applicable)

_____ City/Town

_____ Province

_____ Postal Code

| Container Unique Identifier |
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**Details on Method of Destruction Used:** _____

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❒ By signing below, both parties certify that the substances noted above were altered or denatured to such an extent as to render consumption impossible or improbable.

**Pharmacist-in-Charge:**

_____ Name

_____ Registration #

_____ Signature

_____ Date of Destruction

**Witness:**

_____ Name

_____ Profession

_____ Signature

_____ Date of Destruction

*Use Additional Pages as Necessary*