# Medication and Device Sample Quarterly Report

Complete and return a report for each clinic location to the State Office of Pharmacy each quarter as follows:
January 1-March 31, April 1 -June 30, July 1- September 30, and October 1- December 31. Provide the report within 7 business days of the end of each quarter. Please provide a thoughtful explanation for any discrepancies identified.

**Important:** This report is required to continue utilizing samples.

# Medication and Device Sample Quarterly Report

**Quarter: _____Date of Report:_____**
**District:_____ Clinic Name and Address:_____**
**Is this a Mobile/Temp Location: Yes_____ OR No_____**
**Person Completing the report: _____Phone:_____**

| A. Manufacturer Name<br>B. Representative Name and contact information<br>C. Practitioner Acquiring Sample | Number of Samples Received for the Quarter<br>A. Name<br>B. Strength<br>C. NDC<br>D. Quantity Received | Number of Patients Receiving Samples | Total Inventory at the end of the Quarter | Inventory Discrepancy Quantity (+/-) | Resolution Explanation |
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**Additional Information:**