

IMP RETURN FORM

Sponsor:	Principal Investigator:	Site No.:	Trial code:
Site Address:			
Organization in charge of the IMP destruction:			

Return date: Planned	Return date: Actual
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IMP	Batch No.	Expiry date	Formulation (<i>e.g. blister, vials, etc..</i>)	Dosage	Amount Returned	Comments

Pharmacist's Name:

Signature:

Date:

Investigator's Name:

Signature:

Date: