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Executive Office of Health and Human Services Department of Public Health

Bureau of Health Professions Licensure

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**Board of Registration in Pharmacy Report of Loss of Controlled Substances**

MARYLOU SUDDERS

Secretary

MARGARET R. COOKE

Acting Commissioner

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| --- |
| **Pharmacy Name MA License Number Pharmacy Address City/Town State Zip Code Pharmacy Phone Number** **Manager of Record name (MOR)** **MOR Signature MOR MA License Number** **For details on what and how to report, refer to Policy 2018-05: Requirements and Procedures for Reporting Theft or Loss of Controlled Substances:** http:[//www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/pharmacy/pharmacy-regs/policies/](http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/pharmacy/pharmacy-regs/policies/)**This form must be emailed to:** dhpl-opp.admin@state.ma.us**Specify the name of the pharmacy and town in the subject line.** |
| **1. Date of****Theft / Loss** |  | **If form has been amended, indicate here (i.e.- Amendment #1):** |
| **2. Date Investigation Concluded** |  |
| **3. Loss/Theft****Reported to Police?** |  No Yes- Name, location, and Phone # of Police Department: |
| **4. Reason for Loss** |  Employee Pilferage/Diversion Break-inLost in Transit Customer Theft |  Armed Robbery Other Known Loss (Specify in box #8)  Unknown Loss (Specify in box #8) |
| **5. List the controlled substance(s) that were lost or stolen, in the table “List of Controlled Substances****Lost”, at the end of this document.** |
| **6. Name of employee****(s) allegedly engaged in pilferage, and license number (s), as applicable** | Employee Name: License #: Address: Phone Number: Email Address: |
| **7. Attached****Documents, if applicable** | Police ReportsLoss Prevention Reports Signed voluntary statement orpromissory note | DEA Form 106Security measures taken to prevent future theft/lossOther – Specify: |
| **8. Additional comments:** |

**List of Controlled Substances Lost**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NDC Number** | **Drug Name** | **Dosage****Strength** | **Dosage Form** | **Drug Schedule** | **Quantity** |
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**Please direct any questions to:** dhpl-opp.admin@state.ma.us

 **Submit**