



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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CERTIFIED FAMILY HOME UNUSED MEDICATION FORM

www.cfh.dhw.idaho.gov

Medications that are no longer used by the resident must not be retained by the certified family home for longer than thirty (30) calendar days. A written record of all disposals of drugs must be maintained in the home and will include:

Client Name: _____

Drug Name **AND** Dosage: _____

Number of Pills Disposed: _____

Reason for Disposal: _____

Method of Disposal: _____

Provider Signature: _____ Date: ____ / ____ / ____

Witness Signature: _____ Date: ____ / ____ / ____
(Should be client's family, RN, or Pharmacist):

DHW Review: _____ Date: ____ / ____ / ____
Signature of Reviewer