Pharmaceutical Returns Service
110 Oak Street
North Aurora, IL 60542-1109

CONTROL DRUG REPORT

800-215-5878

DATE _____

CUSTOMER / SENDER			CUSTOMER/SENDER *PHARMACEUTICAL RETURNS SERVICE*		
ADDRESS			ADDRESS *110 OAK STREET*		
CITY	STATE	ZIP	CITY *NORTH AURORA*	STATE *IL*	ZIP *60542-9904*
DEA NUMBER	EXPIR. DATE		DEA NUMBER *RP0194174*		

DRUG NAME OR BRAND NAME *	NDC NUMBER	LOT NUMBER	EXPIR. DATE (M/YY)	- DRUG CLASS - 3	4	5	# OF UNITS IN ORIGINAL PACKAGE?	
SAMPLE DRUG	99999 9999 09	5A5BCD555	12/06	☐	☑	☐	100	200
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		
				☐	☐	☐		

AUTHORIZED SIGNATURE _____ DATE _____

PHOTOCOPY THIS FORM
Return original to PRS and keep one copy for your records.

** Products can ONLY be combined on the same line if the Drug, Exp. Date, and Lot # are identical.*