Summit County Health District

1100 Graham Road Circle ◆ Stow, Ohio 44224-2992
Phone: (330) 926-5778 ◆ Toll-free: 1-877-687-0002 ◆ Fax: (330) 923-6370
www.schd.org

ELIGIBILITY STATEMENT FOR THE DRUG REPOSITORY PROGRAM

Participant Name:________________________________ **DOB:**____/___/______

Address: _______________________________________**Phone:** ________________

City/State/Zip: __________________________________

Alternate Phone: _____________________

Medication Allergies: ____

I, (print name)_________________________________ verify that I am a resident of Summit County and have no reasonable financial means to pay for medication I have been prescribed. For this reason, I am requesting to participate in the Drug Repository Program.

If at anytime I am no longer a resident of Summit County or my financial or insurance situation changes, I will immediately notify Buderer Drug Repository and Summit County Health District.

I hereby give permission to Summit County Health District and Buderer Drug Company, to discuss information related to me and my situation with any parties they find relevant to the positive outcome of my need/problem/concern.

I understand that not all medications will always be in stock.

I agree to pay $7.40 for each prescription plus $7.00 shipping and handling to Buderer Drug Company.

I verify that the information provided is entirely truthful to the best of my knowledge.

_________________________________ _____________________

Participant Signature Date

To be completed by SCHD staff:

Participant has been screened and found to be eligible for the Drug Repository Program thru Summit County Health District

_________________________________ ____________________

SCHD staff member name Date

Date faxed to Buderer Drug Co: Date mailed with order sheet

Fax Number: (419) 626-0494 ______________ ____________________