

RECALL STOCK RESPONSE FORM

**Product Name: Furosemide Tablets USP, 80 mg; NDC # 69315-118-01;
LOT # H03125, H03225, H03325**

RETAIL LEVEL

Please fill out this form completely. By doing so, this will acknowledge that you have read and understand the recall instructions and have taken the appropriate action.

Business Name _____ DEA # _____

**DEA # is required, if not provided the processing of your form will be delayed.*

Address _____

City _____ State _____ Zip _____

Contact Name (please print) _____ Telephone # _____

Contact Signature _____ Date _____

I have checked my stock and:

_____ Do not have any stock of the recalled **items**.

OR

Have quarantined and listed in the box below the quantity of recalled units I will be returning to Inmar, as soon as possible. Upon receipt of this Response Form, Inmar, will issue return authorization label(s). Please indicate the # of needed box labels _____.

Lot #	Exp. Date	Strength	Pkg Size	NDC	Qty of btl's returning

I have identified and notified my customers that were shipped or may have been shipped this product by (specify date and method of notification):

If you did not purchase the product directly from the Manufacturer, please complete the below section.

Purchased From: Wholesaler Name _____ DEA # _____

City _____ State _____

If you have any questions regarding this form or product return please contact Inmar at 1-877-864-9107 Office hours 9am to 5pm EST, Mon thru Fri.

Please fax this form to: 1-817-868-5362 or E-mail: rxrecalls@inmar.com