



RECALL STOCK RESPONSE FORM

**Captopril Tablets USP, 12.5 mg
VOLUNTARY RECALL 03/16/2015**

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.

Customer Name _____ DEA # _____

**DEA # is required, if not provide 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 qty 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 _____.

Item Description	NDC	Lot #	Qty returning
Captopril Tablets USP, 12.5 mg	64679-902-01	LM10525	
Captopril Tablets USP, 12.5 mg	64679-902-02	LM10522	
Captopril Tablets USP, 12.5 mg	64679-902-01	LM10727	
Captopril Tablets USP, 12.5 mg	64679-902-02	LM10726	
Captopril Tablets USP, 12.5 mg	64679-902-01	LM11519	
Captopril Tablets USP, 12.5 mg	64679-902-01	LN11248	
Captopril Tablets USP, 12.5 mg	64679-902-02	LN11281	

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 1-800-967-5952. Office hours 7am to 5pm Mon thru Fri.

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