



RECALL RESPONSE FORM

VOLUNTARY RECALL – RETAIL LEVEL

PRODUCT DESCRIPTION	NDC NUMBER	LOT #	EXP DATE	Units Returning
Promethazine DM Syrup, Promethazine Hydrochloride 6.25 mg, Dextromethorphan Hydrobromide 15 mg, Alcohol 7%, One Pint (473 mL)	0603-1586-58	0000001099	3/16	

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.

The affected product was distributed by Qualitest between January 06, 2015 and January 07, 2015.

Store 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 notified my customers that were sold/shipped affected recalled product

Circle one: YES or NO-I did not sell/ship affected product.

I have checked my stock and:

_____ Do not have any stock of the recalled products listed above.

OR

Have quarantined and listed in the box above the quantity of units the above product lot. I will be returning to CLS MedTurn, an Inmar company, as soon as possible. Upon receipt of this Response Form, CLS MedTurn, an Inmar company, will issue return authorization labels _____ (please indicate the # of box labels needed.)

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

Purchased From: Name _____ DEA # _____

Address _____

City _____ State _____ Zip _____

If you have any questions regarding this form or product return please contact

CLS MedTurn, an Inmar company at 1-800-967-5952

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