|  |
| --- |
| DISPOSAL OF STORED IMP or AMTP checklist |
|  |

BB Number

All relevant fields must be completed. Evidence of authorisation of disposal to be attached.

Trial Name:

Trial Number

Manufacturer

Batch Number/s

Patient Name

Trial ID number

Hospital No:

Date of Birth:

|  |  |  |  |
| --- | --- | --- | --- |
| *Details of product* | | | |
| **Product number** |  | **Dose** |  |
| **Date of Harvest** |  | **Rack &Slot** |  |
| **Date of Expiry** |  | **? GM modified** |  |

|  |  |  |
| --- | --- | --- |
| *Disposal* | *Initial* | *Checked* |
| **Reason for disposal:** |  |  |
| **Trial disposal log completed if applicable** |  |  |
| **Details checked** |  |  |
| **Removed by** |  |  |
| **Method of disposal** |  |  |
| **Disposed of by** |  |  |
| **Documentation attached** |  |  |
| **Copy of this form filed in trial file if applicable** |  |  |