DISPOSAL OF STORED IMP, ATIMP or ATMP BB Number

Please initial when complete. Do not leave blank fields, use N/A if not applicable

Name **Date:**

Date of Birth: **BB number**

Hospital number **DIN (if applicable)**

Written confirmation from Sponsor to destroy ATIMP must be attached.

Trial Name: **Trial Number**

Manufacturer **Batch Number/s**

Patient Trial ID number

Details of product			
Product bag/vial 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		
Bags/vial number disposed of ……		
Disposed of by (Senior member of staff must be involved)		
Documentation attached		
Copy of this form filed in trial file if applicable		