



TENNESSEE
BOARD OF PHARMACY
DEPARTMENT OF HEALTH
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<http://health.state.tn.us/Boards/Pharmacy/>

Tennessee Prescription Drug Redispensing Program Indigent Patient Waiver

I have been qualified as an indigent patient as defined in Tenn. Code Annotated § 63-10-503(5). As an indigent patient who has been authorized by a health care professional to receive prescription medication(s), I am executing this release to request that I obtain my prescription medication(s) through a charitable clinic pharmacy participating in the Tennessee prescription drug redispensing program, established in Tenn. Code Annotated § 63-10-501, *et seq.* as the Nina Norman Prescription Drug Donation Act of 2006.

I understand that the purpose of this pilot program is to improve the health of needy Tennesseans through a prescription drug redispensing program that authorizes charitable clinic pharmacies to redispense medicines that would otherwise be destroyed. I also understand that my participation in this program is voluntary. By participating in this pilot program, I agree that by signing this waiver, I am releasing the institutional facility, the donor patient, and the donor patient's estate from liability. I also acknowledge that the following persons or entities shall not be subject to criminal prosecution, civil action, or professional disciplinary action based on their participation in this pilot program: donor patient and donor patient's estate; institutional facility; prescribing physician, physician's assistant, registered nurse, advanced practice nurse, or nurse practitioner; charitable clinic; charitable clinic pharmacy; the Department of Health; and the Board of Pharmacy.

I also acknowledge that a pharmacist or pharmacy technician who participates in this program and who abides by Board of Pharmacy rules about this pilot program will not be subject to criminal prosecution or civil action. A pharmacist or pharmacy intern who abides by all Board of Pharmacy rules, not just those specific to this program, will not be subject to professional disciplinary action for their participation in the program.

As a participant in this pilot program, I acknowledge that I have received the following prescription medications from _____ (charitable clinic pharmacy) through the pilot program.

Name of Medication(s): _____

Quantity: _____ Rx# Number: _____ Date of Prescription: _____

Signature of Patient

Date