Witness of Controlled Drug Destruction Form

Please complete Sections A to C of the form electronically in advance of the visit, and return to fife.cd@nhs.scot

Section A	
Contractor Reference	
Contact Name	
Telephone Number	
Email	
Premises Name	
Premises Address	
Postcode	
Date	

Section B: Please confirm that the premises has the following	Yes/No
Sufficient destruction kits for the volume of CDs to be destroyed (or these will be ordered and available in advance of the visit).	
All items are recorded in an appropriate CD register.	
Running balances are accurate.	
Are there any unresolved discrepancies?	
PPE is available for staff (Authorised Witness will bring own PPE).	
Do you have an electronic CD register? If so, please state which brand.	

Section C:

Please complete the table below with details of all stock of Schedule 2 Controlled Drugs which require destruction

(Qty Destroyed will be completed with your authorised witness present)

Name of Drug	Form	Strength	Qty for destruction	Register Balance	Physical Balance	Qty Destroyed

Section D	Print Name	Signature	Date of Destruction
Responsible Person			
Role (eg GP, Pharmacist)			
Authorised Witness			
GPHC number			