



## MEDICAL STORES RETURNS AUTHORISATION FORM

### 1. Customer Details:

Institution Name: .....

Name of Requesting Officer: .....

Designation: .....

Date: .....

Approved by: .....

Designation and Sign: .....

Date: .....

### 2. Product Details:

No.	Product Code	Description (Name, form, strength & size)	Pack Size	Qty	Exp date(s)	Reason for Return	Batch No.	Order/Dispatch No. on which supplied	Date Delivered by MSL




**Other comments from the customer:**

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***For MSL use only***

*RETURN AUTHORISED BY:*

*Name*

\_\_\_\_\_

*Designation*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Signature*

\_\_\_\_\_

*All items accepted for return?*

\_\_\_\_\_

*If no, which items will not be accepted?*

\_\_\_\_\_