



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:

For MSL use only

RETURN AUTHORISED BY:

Name

Designation

Date

Signature

All items accepted for return?

If no, which items will not be accepted?
