

## STATEMENT OF DRUGS ADMINISTERED

This form must be submitted by a facility to the West Virginia Division of STD, HIV, and Hepatitis prior to distribution of drugs by the Division to the facility. The information provided on this form will be reconciled with the Division's Central Registry.

Codes for clinic type: FP = Family Planning Clinic STD = STD Clinic

Codes for indication of treatment: S = Signs/Symptoms C = Contact P = Positive Lab

	Patient Name (Last, First)	Clinic Type		Diagnosis	Indication			Drug Name	Dose	Tx Date
		FP	STD		S	C	P			
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										

**Please Complete:**

Name of Facility: \_\_\_\_\_  
 Address of Facility: \_\_\_\_\_  
 Telephone Number: \_\_\_\_\_  
 Fax Number: \_\_\_\_\_  
 Person Authorized to Order Drugs: \_\_\_\_\_  
 Signature: \_\_\_\_\_  
 Date Submitted: \_\_\_\_\_

**Division Use:**  
 Date Order \_\_\_\_\_  
 Processed: \_\_\_\_\_  
 Initials: \_\_\_\_\_

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