DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **MONTHLY DRUG STORAGE INSPECTION FORM** REFERENCE NO. 702.4

Provider Agency: _____ ALS Unit: _____

Date/Time Monthly Drug Storage Inspection Form conducted: _____

VERIFY THE FOLLOWING ITEMS:	**YES**	**NO**
1. Controlled drugs are adequately locked and secured.		
2. Expiration dates were verified. Indicate any expired drugs: _____		
3. Controlled drug physical inventory count matches documentation.		
4. All forms are complete and legible including:		
a. RN printed name and signatures are clearly displayed.		
b. Paramedic signatures and license numbers are clearly displayed.		
c. Name of drug and amount wasted are clearly noted.		
5. Other Findings:		
6. Recommendations:		
7. Actions Taken:		
8. Comments:		
INSPECTOR'S NAME/TITLE:		
INSPECTOR'S SIGNATURE		