



RMA Request Form

This form must be filled out for all return request and emailed to customerservice@ipdpharma.com
for authorization to return product

Business Information

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|------------------|------------|
| Business Name: | Account #: |
| Ship To Address: | City: |
| State: | Zip Code: |
| Phone #: | Fax #: |
| Email: | |

Order information

| Invoice Date | Invoice Number | Item Number | Item Size | Lot Number | Price | Expiration Date | Quantity | Description of Item |
|--------------|----------------|-------------|-----------|------------|-------|-----------------|----------|---------------------|
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Please Advise Reason for Return:

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By returning product(s), you are certifying that all the following statements are true.

- 1.) The specific product(s) were purchased directly from Independent Pharmacy Distributor, LLC
- 2.) That product(s) have been stored properly at a temperature indicated on the product label and in the original bottle.
- 3.) Drug product(s) have never been opened and drug product(s) have never been repackaged, in compliance with the Prescription Drug Marketing Act.
- 4.) Product **NOT** defaced with stickers, price marks, knife cuts, etc.

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|------------|--|
| Signature: | |
| Print: | |
| Date: | |