**Destruction Certificate Form**

I, , hereby certify the destruction of the below unused Campath vials by:

(name of physician or institution representative)

* High temperature incineration
* Other (Please explain):

**Name of Practice or Institution (please print)**

**Physician or Institution Representative (please print)**

**Physician or Institution Representative (signature)**

**Date**

NDC

Drug Name

Dosage

Patient Identifier

(if available)

Number of Vials

Total Volume of Solution

Lot Numbers

Date of Destruction