

12-HOUR CONTROLLED DRUGS-COUNT RECORD

Month _____ Year _____

FACILITY _____ UNIT _____

Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drug Administration Record.

DATE	1st SHIFT		2nd SHIFT		COMMENTS
	Nurse On	Nurse Off	Nurse On	Nurse Off	
1					
2					
3					
4					
5					
6					
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