

8-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	7-3 SHIFT		3-11 SHIFT		11-7 SHIFT		COMMENTS
	Nurse Off (11-7)	Nurse On (7-3)	Nurse Off (7-3)	Nurse On (3-11)	Nurse Off (3-11)	Nurse On (11-7)	
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SAMPLE

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