GOVERNMENT OF BERMUDA

Ministry of Health and Seniors
Office of the Chief Medical Officer

APPLICATION FOR IMPORTATION CONTROLLED DRUGS

This form is to be completed by individuals wishing to import controlled drugs. Please complete this form by printing in **BLOCK CAPITALS** *(Accuracy and clarity are vital when completing this form*). Applications should be submitted in person, fax, or via email (*contact details are at the bottom of the page*). This form should be accompanied with:

- A copy of the relevant prescription or a letter from the prescribing physician (on letterhead with contact details) indicating they prescribed the drug and includes the specific quantity and strength (additional information will be requested, if required for clarification).
- For imports of more than a seven day supply, a letter from a Local Registered Physician indicating approval of use of the product should accompany this application.

DATE: _____ **TIME:** _____

PATIENT NAME: _____

ADDRESS: _____

_____

Telephone Number(s): _____ **E-mail Address:** _____

Please list the details of each Controlled Drug to be imported separately:

#	Name of Drug or Pharmaceutical Product:	Form (Tablets, Ampoules)	Strength	Quantity
1				
Name and Address of Entity from which the Drugs will be imported (Include full mailing address)**:**				

#	Name of Drug or Pharmaceutical Product:	Form (Tablets, Ampoules)	Strength	Quantity
2				
Name and Address of Entity from which the Drugs will be imported (if different from above)**:**				

#	Name of Drug or Pharmaceutical Product:	Form (Tablets, Ampoules)	Strength	Quantity
3				
Name and Address of Entity from which the Drugs will be imported (if different from above)**:**				

I _____, verify that the information provided in this application are true and correct to the best of my knowledge and understand and agree to that any residual product is disposed of by the Bermuda Police Service or the Pharmacy Inspector.

_____ _____

(Signature) **(Date)**

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