CONTROLLED MEDICATION COUNT

Consumer ___________________________________

Medication__________________________

Dose_______________________________

Month/Year_________________________

DATE	1st Shift Count	On	Off	2nd Shift Count	On	Off	3rd Shift Count	On	Off
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									

Please sign and initial below to identify initials used in “on” and “off” columns above.

Signature	Initial	Signature	Initial	Signature	Initial

APD Form 65G7-07, adopted 3/10/08 by Rule 65G-7.007(8)(b)3, F.A.C.