



CUSTOMER RECALL RETURN RESPONSE FORM

PLEASE FAX COMPLETED RESPONSE FORM TO 1-877-625-2717 (1-877-6CLARIS)

Product details	NDC	Lot Numbers
Ciprofloxacin in Dextrose (5%) Inj., USP 200mg/100mL Bag	36000-008-24	All Lot Numbers
Ciprofloxacin in Dextrose (5%) Inj., USP 400mg/200mL Bag	36000-009-24	All Lot Numbers
Metronidazole Injection, USP 500mg/100mL Bag	36000-001-24	All Lot Numbers
Ondansetron in Dextrose (5%) Inj., 32mg/50mL Bag	36000-014-06	All Lot Numbers

Please check ALL appropriate entries

___ I have read and understand the recall instructions provided in the Customer Notification/Recall Communication letter dated May 30, 2010.

___ I have checked my stock and have quarantined inventory consisting of _____ units (IV Bags).

Indicate disposition of recalled product:

Ciprofloxacin in Dextrose (5%) Inj., USP 200mg/100mL Bag, NDC: 36000-008-24

Disposition	Quantity	Date	Method
returned			
destroyed			
quarantined			

Ciprofloxacin in Dextrose (5%) Inj., USP 400mg/200mL Bag, NDC: 36000-009-24

Disposition	Quantity	Date	Method
returned			
destroyed			
quarantined			

Metronidazole Injection, USP 500mg/100mL Bag, NDC: 36000-001-24

Disposition	Quantity	Date	Method
returned			
destroyed			
quarantined			

Ondansetron in Dextrose (5%) Inj., 32mg/50mL Bag, NDC: 36000-014-06

Disposition	Quantity	Date	Method
returned			
destroyed			
quarantined			

Clarís Lifesciences Inc.

1445, US Highway 130, North Brunswick,
NJ 08902, USA. Tel : 1 732 422 9100
Email: claris@clarislifesciences.com
www.clarislifesciences.com



___ I have identified and notified my customers that were shipped or may have been shipped this product and have communicated that we are conducting a sub-recall to our direct account customers

Date of communication: _____

Method of communication: _____

Have there been any Adverse Events associated with recalled product? ___ Yes ___ No

If yes, please explain _____

Please check the appropriate entries to describe your business

- | | | | |
|---|--|---|-----------------------------------|
| <input type="checkbox"/> Wholesaler/distributor | <input type="checkbox"/> Retailer | <input type="checkbox"/> Pharmacy-retail | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Pharmacies | <input type="checkbox"/> Hospital/Medical facility | <input type="checkbox"/> Medical laboratory | <input type="checkbox"/> Other |

Please provide Contact Information for Person Completing Response:

Name : _____

Title : _____

Tel Number : _____

Facility : _____

Address : _____

City, State, Zip : _____

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