47 Mall Dr, Unit 1& 2,
Commack, NY-11725
sales@akrongenerics.com
Phone: 631-215-3009
Fax: 631-215-3099
www.akrongenerics.com

RETURN AUTHORIZATION FORM

Dear Customer,

Please sign and date on the spaces provided below and fax this back to us as soon as possible. We will Issue a call tag to have the goods picked up from your location upon receipt of this completed Return Authorization form.

Return Information	
Date Requested	
Customer Name	
Address	
Phone #	
Fax #	

NDC	Product Name	STR	Size	Lot	Exp. Date	QTY	Invoice #	Invoice Date

Reason for Return/Recall/Withdrawal:

The undersigned guarantees that all products returned to Akron Generics have been stored, handled and Shipped in accordance with manufacturer guidelines, Federal, State and Local Laws, including the Prescription Drug Marketing Act requirements of f.s. 499.0121 and the rules adopted there under while
in the purchaser's custody and control. Any products not meeting the above requirements are not eligible for return or credit. All products returned must be authorized in advance. Akron Generics reserves the right to return or destroy products that are ineligible for credit or sent without prior authorization Furthermore, the undersigned also guarantees by signing, that the specific unit (exact unit) being returned was purchased from Akron Generics.

Customer Name (Signature): _____

Customer Phone Number: _____

Customer Name (Printed):_____**Business Title:** _____

Fax completed form to: 631-215-3099.

Upon Completion and return of this form, a return label will be mailed or faxed to you so return process can be started.