2611 N. San Fernando Road, Los Angeles, CA 90065
Phone: (323) 227-4831, **Fax: (323) 227-4833**
e-mail: solutions@meritpharm.com / web: www.meritpharm.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.

Date Requested:	
Customer #:	
Customer Name:	
Address:	
e-mail:	
Phone:	
Fax:	

NDC	Description	Qty	Invoice #	Invoice Date	Reason

- All returns must be within **15 days** from date of invoice.
- All items returned must be saleable, unopened, original container.
- Special ordered items and refrigerated items may not be returned. Please inquire.
- Returned items may be subject to a Restocking Fee.

The undersigned guarantees that all products returned to Merit Pharmaceutical 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. Merit 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 Merit. Upon completion and return of this Return Authorization, Merit will send pick up tags for the returns in accordance with our return policy.

Customer Name (Signature): ______________________________
Customer Name (Printed): ______________________________
Business Title: ______________________________

Fax completed form to: (323) 227-4833