MEDICAL SUPPLY DONATION LIST

Team Name:

Travel Dates:

Name of Medicine	Exp. Date	Manufacturer	Quantity and Unit(s)	Value
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				

Please complete this form and return it to the HOI office at least four weeks prior to departure and be sure to carry a copy of it with you the day you travel to Honduras.