1. RECALL INFORMATION
   a. RES/RECALL NUMBER(S)  b. RECALLING FIRM  c. RECALLED CODE(S)  d. PRODUCT(S)

2. PROGRAM DATA
   a. HOME DISTRICT  b. FEI NUMBER OF RECALLING FIRM  c. PAC CODE  d. HOURS

3. AUDIT ACCOUNTS
   a. DIRECT  b. SUB-ACCOUNT (SECONDARY)

4. CONSIGNEE DATA
   Contacted by:  Phone  Visit  Other
   a. NAME OF PERSON CONTACTED & TITLE  b. TYPE CONSIGNEE
      Distributor  Consumer  Pharmacy  Retailer  Physician  Restaurant  Processor  Hospital  School  Other:

5. NOTIFICATION DATA
   a. DID CONSIGNEE FOLLOW THE RECALL INSTRUCTIONS? (If "No", skip to item 6c.)
      Yes  No  Cannot be determined (If answer is other than "No", explain in remarks.)
   b. RECALL NOTIFICATION RECEIVED FROM
      Recalling Firm  Other (Specify below)
      Direct Account  Sub-Account
   c. DATE NOTIFIED (mm/dd/yyyy)
   d. TYPE OF NOTICE RECEIVED (e.g., letter, phone)

6. ACTION AND STATUS DATA
   a. AMOUNT OF RECALLED PRODUCT ON HAND AT TIME OF NOTIFICATION
   b. CURRENT STATUS OF RECALLED ITEMS
      Returned  None on Hand  Destroyed  Held for Return/Correction*
      Corrected  Was Still Held for Sale/Use*  Other:
      *(Ensure Proper Quarantine/Action

7. SUB-RECALL NEEDED?
   Did consignee distribute to any other accounts? (If "Yes", collect information and/or provide details in "Remarks" or Memo.)
   Yes  No

8. AMOUNT OF RECALLED PRODUCT NOW ON HAND
   a. NAM E OF PERSON CONTACTED & TITLE
   b. TYPE CONSIGNEE
      Distributor  Consumer  Pharmacy  Retailer  Physician  Restaurant  Processor  Hospital  School  Other:
   c. DATE NOTIFIED (mm/dd/yyyy)
   d. TYPE OF NOTICE RECEIVED (e.g., letter, phone)

9. INJURIES/COMPLAINTS
   a. IS CONSIGNEE AWARE OF ANY INJURIES, ILLNESS, OR COMPLAINTS?
      Injury  Complaint  Illness  None
      (If answer is other than "None", report details in a separate memo to monitoring district and copy to CEO (HFA-615)).

10. REMARKS (Include action taken if product was still available for sale or use.)

CHECK

SCSO OR R&E COORDINATOR

ENDORSEMENT

INVESTIGATOR

Signature

Printed Name

Date of Check (mm/dd/yyyy)

District

FORM FDA 3177 (2/10)  RECALL AUDIT CHECK REPORT