



SAGENT™

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CUSTOMER RECALL RETURN RESPONSE FORM

PLEASE FAX COMPLETED RESPONSE FORM TO 1-847-908-1827 (ATTN: QA Dept)

Product	Lot Number(s)	NDC Number
Metronidazole Injection, USP 500mg/100mL	A090742, A090743, A090744, A090745, A090746, A090769, A090770, A090771, A090772, A090773, A090774, A090775, A090776, A090968, A091014, A000013, A000016 and A000019	25021-131-82

Please check ALL appropriate boxes.

- I have read and understand the recall instructions provided in the Customer Notification/Recall Communication letter dated May 13, 2010.
- I have checked my stock and have quarantined inventory consisting of _____ units (IV Bags).

Indicate disposition of recalled product:

Disposition	Quantity	Date	Method
<input type="checkbox"/> returned			
<input type="checkbox"/> destroyed			
<input type="checkbox"/> quarantined			

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 box(es) to describe your business			
<input type="checkbox"/> wholesaler/distributor	<input type="checkbox"/> retailer	<input type="checkbox"/> pharmacy – retail	<input type="checkbox"/> hospital pharmacies
<input type="checkbox"/> hospital/medical facility	<input type="checkbox"/> medical laboratory	<input type="checkbox"/> Other: _____	

Please Complete Contact Information for Person Completing Response:	
Name:	_____
Title:	_____
Tel Number:	_____
Facility:	_____
Address:	_____
City, State, Zip:	_____