Kentwood Pharmacy Questionnaire

1. Name (last name, first name):

2. Date of Birth:

3. Address:

4. Telephone numbers (home, work and cellphone):

5. E-mail Address:

6. Name of long term care facility at which you resided or the Kentwood Pharmacy retail location at which you purchased drugs.

7. Time period that you resided at long term care facility or the time period that you purchased drugs at a Kentwood Pharmacy location.

8. Why do you believe that you are a victim in this matter? For example, do you have some reason to believe that you received misbranded, adulterated or expired drugs? Do you have some reason to believe that your drugs were improperly billed?

Please return this form to the following address no later than November 1, 2013.

Victim/Witness
U.S. Attorney's Office
P.O. Box 208
Grand Rapids, MI 49501-0208
kathy.schuette@usdoj.gov
Phone (616) 808-2034
Fax (616) 456-2696