Medication Expiration Policy Confirmation Request

Date: [Insert Date]

To: [Recipient's Name]

[Recipient's Title]

[Organization's Name]

[Organization's Address]

Dear [Recipient's Name],

I hope this message finds you well. As part of our commitment to maintaining the highest standards of safety and compliance, we are reaching out to confirm our medication expiration policy.

We kindly request your confirmation of the following points related to our medication expiration policy:

- All medications should be checked for expiration dates quarterly.
- Expired medications must be disposed of properly within two weeks of the expiration date.
- Records of medication disposal should be maintained for auditing purposes.

Please confirm if these points align with your understanding and acceptability of our policy. If there are any discrepancies or additional procedures you believe should be included, do not hesitate to let us know.

Thank you for your attention to this matter.

Best regards,

[Your Name]

[Your Title]

[Your Organization]

[Your Contact Information]