

DO NOT write your name (or the name of the person for whom you are returning medicine) anywhere on this form.

Please Complete
Safe Medicine Disposal for ME Program Survey



INSTRUCTIONS:

1. Before completing this survey, please read through the survey instructions provided to you with your envelope.
2. This form is for research purposes only. Research findings will help us to design more medicine disposal opportunities for Maine residents and create a national model.
3. You do not need to complete this survey in order to return your medicines. If you choose to take the survey, please return it in the same pre-paid envelope given to you to return your medicine.

NOTE: If you need help filling out this form, please call: 1-866-637-9743

Please check the appropriate boxes or write in the spaces provided. You may skip any questions you do not want to answer.

**1. Have you returned medicine using *this* mailback program before?
(Please check (✓) one)**

- Yes No, this is my first time returning medicine using *this* program.

Your age: _____ years

For the questions below, please tell us about yourself and the medicine you are returning. If you are returning medicine for someone else or for more than one person, **please tell us about the person for whom most of the medicine was prescribed.**

2. The medicine(s) I am disposing is: (Please check (✓) all that apply)

- My own medicine
 A relative's medicine
 A deceased friend or relative's medicine
 A friend's medicine
 Pet/Veterinary medicine
 I don't know whose medicine it is

3. Home zip code: _____

4. Gender: Male Female

5. Age: _____ years

6. Are there any people living in the household in the following age groups? (Please check (✓) all that apply)

- Newborn to 10 years
 11 to 20 years
 21-64 years
 65+ years

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7. How did you normally dispose of your unused and unwanted medicine before today? (Please check the method you used most often)

- Flush down the toilet
- Put in trash
- Bring to a drug collection event or give to law enforcement officer
- Don't know
- Other: _____

8. Where did you get these medicines? (Please check (✓) all that apply)

- Sample given to me at the doctor's office
- Local pharmacy
- Internet pharmacy
- Mail order pharmacy
- Given to me by a friend or family member
- Other (please list): _____

9. Why do you want to get rid of these medicines? (Please check (✓) all that apply)

- Medicine is expired or outdated
- Doctor told me to stop taking the medicine(s)
- Doctor gave me new medicine(s) to take instead
- I had a reaction or allergy to the medicine(s)
- I did not like the side effects
- I did not want to take it
- I got better/did not need it any more
- I don't want anyone else to use them
- Other (please list): _____
- I don't know/I don't remember

10. How important are the following reasons in your decision to use this envelope to return unused medicines?

Please place only one check by the most important reason to you.

- a) Best for the environment _____
- b) Safest for me and my family _____
- c) Most convenient to use _____
- d) Free to use _____

11. How helpful is this medicine mail-back disposal program to you?

- Very helpful
- Helpful
- Somewhat helpful
- Not helpful

12. What can we do to improve this program? (please write in)

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When complete, please fold the survey and place it into the envelope along with the medicines you are mailing back. For more information about the Safe Medicine Disposal for ME Program please visit: www.safemeddisposal.com or call 1-866-ME-RX-RID (1-866-637-9743). **Thank you.**