# Please Complete
# Safe Medicine Disposal for ME Program Survey

**INSTRUCTIONS:**

1. Before completing this survey, please read through the instruction booklet provided to you with your envelope.

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

3. This form is for research purposes only. Research findings will help us to design more medicine disposal opportunities for Maine residents.

4. 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.

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 are: (Please check (✓) all that apply)**

☐ My own medicine
☐ A 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. Age of any other people living in the household:**

**Please circle the number of people in each age group:**

| | | | | |
|---|---|---|---|---|
| Newborn to 10 years | 0 | 1 | 2 | 3 or more people |
| 11 to 20 years | 0 | 1 | 2 | 3 or more people |
| 21-64 years | 0 | 1 | 2 | 3 or more people |
| 65+ years | 0 | 1 | 2 | 3 or more people |

**-Please Turn Over-**

**7. What kind of medicine are you getting rid of? (Please check (✓) all that apply)**

- ☐ Antibiotics
- ☐ Allergy or asthma medicine
- ☐ Heart, blood pressure, or cholesterol medicine
- ☐ Pain or anti-inflammatory medicine
- ☐ Sleep or anxiety medicine
- ☐ Other (please list):________________________
- ☐ I don't know

**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
- ☐ 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 <u>only one check</u> 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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**<u>When complete, please fold the survey and place it into the envelope along with the medicines you are mailing back</u>.** 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.**