



| Date | Time | Customer | Staff Member | Type of Error | Reason for Error | Action Taken |
|------|------|----------|--------------|---|------------------|--------------|
| | | | | <input type="checkbox"/> Wrong Drug <input type="checkbox"/> Wrong Strength <input type="checkbox"/> Wrong Directions <input type="checkbox"/> Other | | |
| | | | | <input type="checkbox"/> Wrong Drug <input type="checkbox"/> Wrong Strength <input type="checkbox"/> Wrong Directions <input type="checkbox"/> Other | | |
| | | | | <input type="checkbox"/> Wrong Drug <input type="checkbox"/> Wrong Strength <input type="checkbox"/> Wrong Directions <input type="checkbox"/> Other | | |
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