

CHDP Oral Health Program

FLOURIDE VARNISH INVENTORY AND FAX COVER SHEET

FAX To: (805) 658-4505 by the 3RD of each month

Medical Office Name: _____

Person tracking inventory: _____

Month: _____

Inventory Count

Start of Month Balance	Distributed Amount	Total FV used	Total FV Received	End of Month Balance

This section does not apply to all offices

Medical Assistant Name	Distributed Amount	Date	Total Used	Amount Left
Totals in Month				

Comments: _____
