

Mars Wrigley Confectionery US LLC

800 HIGH STREET

HACKETTSTOWN, NJ 07840

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**MARS WRIGLEY US LLC ISSUES VOLUNTARY RECALL OF SKITTLES® Gummies, STARBURST® Gummies and LIFE SAVERS® Gummies**

**Please check ALL appropriate boxes and completed the requested information indicating quantities, dates and send to the contact indicated below.**

|  |  |
| --- | --- |
|  | BOX |
| I have read and understand the recall instructions provided in the May 13, 2022 letter. |  |
| I have checked my stock and have quarantined inventory consisting of |  |
| Please indicate Case Number: |  |
| Indicate disposition of recalled product: |  |
| Returned/held for return please specify **quantity, date and method** |  |
| Quantity |  |
| Date product on hold |  |
| Return \_\_\_\_\_ or Destroy \_\_\_\_\_\_\_\_\_ |  |
| Destroyed please specify **quantity, date and method** |  |
| Quantity |  |
| Date product on hold |  |
| Destruction Method:\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Quarantined pending correction. Please specify quantity quarantined |  |
| Quantity Quarantined |  |
| I have identified and notified my customers that were shipped or may have been shipped this product. |  |
| Please specify date and method of notification to customers |  |
| Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  |  |
| Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Any adverse events associated with recalled product? |  |
| YES |  |
| NO |  |
| If yes, please explain: |  |

Please complete Certificate of Destruction details below, required for both reimbursement and re-shipment:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **UPC** | **Batch Code** | **Quantity** | **Unit (case/pouch)** |
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Please check the appropriate box(es) to describe your business

|  |  |
| --- | --- |
| Wholesaler/distributor |  |
| Retailer |  |
| Grocery corporate headquarters |  |
| Food service/restaurant |  |
| Repacker |  |
| Manufacturer |  |
| Pharmacy - retail |  |
| Hospital/medical facility |  |
| Other, please specify |  |

Please complete the information below

|  |  |
| --- | --- |
| Name: |  |
| Title: |  |
| Tel. number: |  |
| Firm name |  |
| Address: |  |
| City/State: |  |

Send form to: [CustomerProductFeedback@effem.com](mailto:CustomerProductFeedback@effem.com) 