Employer-Based Training Program Attestation

To be used by Registered or Certified Pharmacy Technician Applicants ONLY.

Part 1 – Applicant Information - *To be completed by the applicant.*

First Name		Last Name
Year of Birth (YYYY)	Last Four Digits of SSN	Name of Employer
Address of Employer		TDDD License No.

Part 2 - Verification of Training by the Program Director - *To be completed by the technician training program director.*

ON BEHALF OF THE TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS LISTED IN THIS APPLICATION, I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE EMPLOYER-BASED PHARMACY TECHNICIAN TRAINING PROGRAM ADMINISTERED BY THE RESPONSIBLE PERSON IN PART 3 OF THIS FORM MEETS THE REQUIREMENTS OUTLINED IN RULE 4729:3-3-02 OF THE OHIO ADMINISTRATIVE CODE.		
Signature of Program Director		Date Signed
Print/Type Name of Program Director	Pharmacist License No.	Contact Phone No. (include area code)

Part 3 – Attestation by the Responsible Person - *To be completed by the responsible person (RP) of the pharmacy where the applicant is currently employed.*

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE APPLICANT LISTED IN PART 1 OF THIS FORM HAS SUCCESSFULLY COMPLETED AN EMPLOYER-BASED PHARMACY TECHNICIAN TRAINING PROGRAM AND DEMONSTRATES COMPETENCY TO SAFELY AND EFFECTIVELY PRACTICE AS A CERTIFIED OR REGISTERED PHARMACY TECHNICIAN AND THE ANSWERS PROVIDED ON THIS FORM ARE **TRUE, CORRECT, AND COMPLETE.**	
Signature of Responsible Person	Date Signed
Print/Type Name of Responsible Person	Ohio Pharmacist License No.
Responsible Person Email Address	Contact Phone No. (include area code)