Steven W. Schierholt, Esq.
Executive Director

STATE OF OHIO BOARD OF PHARMACY

John R. Kasich
Governor

RESPONSIBLE PERSON REQUEST FOR MORE THAN ONE PAIN MANAGEMENT CLINIC

PLEASE TYPE OR PRINT LEGIBLY

1. **Complete the form, print e-mail address, phone number, sign, and date.**
2. **Make a copy for your file.**
3. **COMPLETED FORM MAY BE SCANNED AND EMAILED, FAXED, *OR* MAILED TO THE CONTACT INFORMATION ON THE FIRST PAGE OF THIS FORM.**

Full Name of Responsible Person	Professional License Number (if applicable)	
Practice Name #1	TDDD License Number #1	DEA #
Practice Location Address #1		
Practice Location Name #2	TDDD License Number #2	DEA #
Practice Location Address #2		

If you wish to be the Responsible Person at more than two locations, attach an additional sheet with the wholesaler name, WDDD license number and address of each location.

Have you received prior approval?

☐ Yes, Provide date(s): _____ ☐ No

Answer the following questions, failure to answer all of the questions makes your request incomplete, delaying the approval process. Attach an additional sheet if you require more space for your responses (include a corresponding question number).

1) Why do you want to be the Responsible Person for more than one location? Provide any other narrative or documentation you believe will assist the Board in processing your request?

2) Is this a permanent or temporary request? What is the timeframe for your request (include specific dates)?

3) What is the distance between the locations?

4) What are the hours of operation for each location?	
Practice Location #1:	Practice Location #2:

5) How many hours will you work at each location, what dates and times will you be present at each location?	
Practice Location #1:	Practice Location #2:

6) Do you personally furnish (provide medication for patient to take home for future use, even if only one dose) at either location? If yes, list the medications that are personally furnished? If you are personally furnishing controlled substances, are you reporting these transactions to OARRS?

7) Are there any other prescribers at these locations? Provide their name, license member, and if they are full-time or Part-time.	
Practice Location #1:	Practice Location #2:
Prescribers:	Prescribers:
Mid-Level Practitioners:	Mid-Level Practitioners:

8) Are both locations utilizing OARRS?	
Practice Location #1:	Practice Location #2:
Utilizing OARRS:	Utilizing OARRS
Reporting to OARRS (if applicable):	Reporting to OARRS (if applicable):
Full name of Prescriber(s):	Full Name of Prescriber(s):
Delegates:	Delegates:

I attest that I have read OAC 4729-5-11 , meet and willcomply with the requirements of the rule(s) as set forth. The information provided is an accurate reflection of the activity for which approval is requested.

Print/Type Name of Responsible Person	Signature of Responsible Person	Date

Email Address	Phone Number (including area code)

COMPLETED FORM MAY BE SCANNED AND EMAILED, FAXED, *OR* MAILED TO THE CONTACT INFORMATION IN ABOVELETTERHEAD