Board of Pharmacy

Automated Pharmacy Systems Request Form

This form must be submitted via email to: compliance@pharmacy.ohio.gov.

Part I – Licensee Information

Name of Licensee	TDDD License No.
Street Address	Name of Responsible Pharmacist (RP)
City	RP Contact Phone (xxx-xxx-xxxx)
Zip Code	RP E-Mail Address

NOTE: *If requesting approval of the same system at multiple locations, please append a list to this form of all licensed locations where you are seeking approval. The list and this form must be uploaded as one file.*

Part II – System Information

Name of System	Manufacturer
Requested Approval Date	

Pharmacist Final Verification:

The system will not require final verification (i.e., the final check) by a pharmacist.

REMINDER: Each system that does not require final verification must submit accuracy metrics using a form developed by the Board. The form must be submitted by email to: compliance@pharmacy.ohio.gov.

The system will be used to assist in the dispensing process, but all medications will be verified (i.e., the final check) by the pharmacist.

Briefly describe the intended use of the automated pharmacy system:

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