Written Notice of Discontinuing Business

Updated 2/4/2025

OAC 4729:5-2-04 and OAC 4729:6-2-06 require a terminal distributor or drug distributor to notify the Board within thirty days of discontinuation of business. Notification must be completed using this form.

INVENTORY REMINDER: On the date of discontinuing business, a complete inventory of all controlled substances being transferred, or disposed of shall be made. The inventory shall list the name, strength, dosage form, and quantity of all controlled substances transferred or disposed.

This inventory shall serve as the final inventory of the licensee discontinuing business and the initial inventory of the licensee to whom the controlled substances are being transferred. A copy of the inventory shall be included in the records of each licensee involved in the transfer.

Instructions:

- To be used by Terminal Distributor or Drug Distributor applicants and those applying for renewal **ONLY**.
    - "Drug Distributor" includes the following license types: Wholesale Distributors of Dangerous Drugs (virtual and brokers), Manufacturers of Dangerous Drugs, Outsourcing Facilities, Repackagers of Dangerous Drugs, Third-Party Logistics Providers, Brokers and Virtual Wholesale Distributors of Dangerous Drugs.
- Home Medical Equipment Services Providers must use this form: www.pharmacy.ohio.gov/HMEdcb.
- This form must be submitted *via email (new.license@pharmacy.ohio.gov) or via eLicense Ohio*.

77 S. High Street, 17th Floor
Columbus, OH 43215 U.S.A.
Phone: 614 | 466 4143
Fax: 614 | 752 4836

Patient Notification Requirements for Pharmacies that Close:

In addition to notifying the Board, OAC 4729:5-2-04 requires any terminal distributor of dangerous drugs licensed as a pharmacy that is permanently closing to:

1. Provide notification, using the information on file with the pharmacy, to each patient who has filled a prescription within the previous six months. This notification must be made a minimum of fifteen calendar days prior to closing and must include:
   (a) The last day the pharmacy will be open;
   (b) Name, address, and telephone number of the pharmacy that will take possession of the pharmacy records or the person who will serve as the custodian of records;
   (c) Instructions on how patients can arrange for transfer of their pharmacy records to a pharmacy of their choice; and
   (d) The last day a transfer may be initiated.

2. The notification shall be made via:
   (a) Direct mail, e-mail, or text message; and
   (b) Posting a closing notice on each pharmacy entrance, on each telephone greeting, and pharmacy-operated internet (e.g., website, social media, mobile applications).

3. Provide any new patients filling prescriptions during the fifteen-calendar day period prior to the pharmacy closing with written notification that includes:
   (a) The last day the pharmacy will be open;
   (b) Name, address and telephone number of the pharmacy to which pharmacy records will be transferred or the person who will serve as the custodian of pharmacy records;
   (c) Instructions on how patients can arrange for transfer of their pharmacy records to a pharmacy of their choice; and
   (d) The last day a transfer may be initiated.

Written Notice of Discontinuing Business

Instructions:

1. *Complete the form, sign, and date.*
2. *Make a copy for your file.*
3. *Submit to the Board via email (new.license@pharmacy.ohio.gov) or via eLicense Ohio.*

Part 1 – Licensee Information

Business Name	**License Number**
Street Address	**County**
City, State, Zip	**Phone (XXX-XXX-XXXX)**

Part 2 – Reason for Discontinuation (select one)

- ◯ **Closure**
- ◯ **Ownership Change**
- ◯ **Other (please provide a short description):**

Part 3 – Date of Discontinuation

Date of Discontinuation (MM/DD/YYYY)

Part 4 – Transfer of Drug Stock - *Select all the apply.*

- ◯ No drug stock on-site.
- ◯ Drug stock to be disposed of on-site. Records of disposal must be maintained in accordance with the Ohio Administrative Code.
- ◯ Drug stock is being transferred (include those who may be engaged in drug disposal) to another business or location. **Provide business/location information below.**

Business/Location Name	**License Number (if applicable)**
Street Address	**County**
City, State, Zip	**Phone (XXX-XXX-XXXX)**

(Attach separate sheet if drug stock is being transferred to multiple locations.)

Part 5 – Location Where Drug Records will be Maintained

Location Name	**License Number (if applicable)**
Street Address	**County**
City, State, Zip	**Phone (XXX-XXX-XXXX)**
Is this location receiving active patient prescriptions? **Yes** ◯ **No/Not Applicable** ◯	

(Attach separate sheet if records are being maintained at multiple locations.)

Part 6 – Attestation - *To be completed by the licensee's Responsible Person, owner, or individual who is otherwise authorized to sign for this licensee. Digital or wet ink signatures are accepted.*

<table>
<tr><td colspan="3">I DECLARE UNDER THE PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE ANSWERS PROVIDED ON THIS FORM ARE TRUE, CORRECT, AND COMPLETE.</td></tr>
<tr><td colspan="2">Signature</td><td>Date Signed</td></tr>
<tr><td colspan="3">Print Name</td></tr>
<tr><td>Contact Phone</td><td colspan="2">Contact Email</td></tr>
<tr><td colspan="3">Please indicate you are signing as one of the following:
◯ Licensee
◯ Owner
◯ Individual who is otherwise authorized to sign for the licensee</td></tr>
</table>