



BORDER STATE SHIPMENT REQUEST FORM

Pursuant to [Board guidance](#) issued on April 14, 2020, this notification form must be submitted and approved prior to the shipment of non-reportable, patient-specific medications into the state by a non-Ohio licensed facility. **Completed forms must be submitted electronically to: compliance@pharmacy.ohio.gov**

IMPORTANT: Only one form per border state facility must be submitted.

PART 1 – UNLICENSED BORDER STATE FACILITY INFORMATION – Complete all the information for the unlicensed facility. Each unlicensed facility must submit a separate form.

Facility Name		Facility's Home State (select one)	
Home State License Number		Type of Facility (select one)	
Address of Facility		City	Zip Code
Full Name of Facility Contact Person	Contact Person's Phone	Contact Person's Email	

PART 2 – DESCRIPTION OF DRUGS INTENDED TO BE SHIPPED – Provide a brief description of the types of patient-specific drugs that will be shipped into the state by the unlicensed facility. Be sure to include an estimate of the number of patients that will be served.

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PART 3 – ATTESTATION – To be completed by a person who has the authority to sign on behalf of the unlicensed facility. Electronic or digital signatures **will not** be accepted.

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE INFORMATION PROVIDED IN THIS FORM IS TRUE, CORRECT, AND COMPLETE. I FURTHER ATTEST THAT THE FACILITY LISTED IN PART 1 THIS FORM WILL COMPLY WITH THE RESOLUTION GUIDANCE ISSUED ON APRIL 14, 2020 AND ANY SUBSEQUENT UPDATES ISSUED BY THE BOARD OF PHARMACY.		
Signature of the Person Authorized to Sign on Behalf of the Facility		Date Signed
Print or Type Full Name	Contact Email	Contact Phone (inc. area code)

77 South High Street, 17th Floor, Columbus, Ohio 43215

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