Responsible Person Request for More Than One PMC

1. *Complete the form, sign, and date.*
2. *Make a copy for your file.*
3. *Completed form and any supporting materials must be emailed to: new.license@pharmacy.ohio.gov.*

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

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

Have you received prior approval?

☐ Yes, Provide date(s): _____ ☐ No

Failure to answer all the questions makes your request incomplete and could delay the review 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 PMC? 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) Describe the nature and/or business at each location (including the number of patients treated for pain and if the prescribers are registered and using OARRS)?	
PMC Location #1:	PMC Location #2

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

6) How many hours will you, the Responsible Person, work at each location, what dates and times will you be present at each location?	
PMC Location #1:	PMC Location #2:

7) How many physicians or prescribers work at each location? Provide their name, license member, and if they are full-time or part-time.	
PMC Location #1:	PMC Location #2:

8) 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?

I DECLARE UNDER 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.**

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

Email Address	Contact Phone Number (including area code)

Completed form and any supporting materials must be emailed to:
new.license@pharmacy.ohio.gov.