Responsible Person Request for More Than One Pharmacy

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	**Pharmacist License No.**	
Pharmacy Location Name #1	**TDDD License Number #1**	**DEA #**
Pharmacy Location Address #1		
Pharmacy Location Name #2	**TDDD License Number #2**	**DEA #**
Pharmacy Location Address #2		

If you wish to be the Responsible Person at more than two locations, attach an additional sheet with the pharmacy 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 pharmacy? You may 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? Do either pharmacies dispense to OUTPATIENTS?	
Pharmacy Location #1:	Pharmacy Location #2:

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

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

7) How many pharmacists work at each location? Provide the name of each pharmacist along with their license number, and if they work full-time or part-time.	
Pharmacy Location #1:	Pharmacy Location #2:

8) Are both locations reporting sales information to OARRS? If not, do you have an exemption?	
Pharmacy Location #1:	Pharmacy Location #2:
Reporting to OARRS: YES ◯ NO ◯	Reporting to OARRS: YES ◯ NO ◯
Exempt: YES ◯ NO ◯	Exempt: YES ◯ NO ◯
Full name of Reporting Pharmacist:	Full Name of Reporting Pharmacist:

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 SCANNED AND EMAILED TO:

***new.license@pharmacy.ohio.gov*.**