Steven W. Schierholt, Esq.
Executive Director

STATE OF OHIO BOARD OF PHARMACY

John R. Kasich
Governor

RESPONSIBLE PERSON REQUEST FOR MORE THAN ONE WHOLESALE DISTRIBUTOR OF DANGEROUS DRUGS

Effective September 1, 2016, rule 4729-5-11 of the Ohio Administrative Code states a responsible person shall not be designated the responsible person for more than one location licensed as a wholesale distributor of dangerous drugs unless granted permission by the Board. To request permission, please complete and submit the following form.

PLEASE TYPE OR PRINT LEGIBLY

1. **Complete the form, print e-mail address, phone number, sign, and date.**
2. **Make a copy for your file.**
3. **COMPLETED FORM MAY BE SCANNED AND EMAILED, FAXED, *OR* MAILED TO THE CONTACT INFORMATION ON THE FIRST PAGE OF THIS FORM.**

Full Name of Responsible Person	License Number (if applicable)		
Title of Responsible Person			
Wholesaler Location Name #1	WDDD License Number #1	CS License # (if applicable)	DEA Number #1 (if applicable)
Wholesaler Location Address #1			
Wholesaler Location Name #2	WDDD License Number #2	CS License # (if applicable)	DEA Number #2 (if applicable)
Wholesaler Location Address #2			
Wholesaler Location Name #3	WDDD License Number #3	CS License # (if applicable)	DEA Number #3 (if applicable)
Wholesaler Location Address #3			

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

Have you received prior approval?

☐ Yes, Provide date(s): _____ ☐ No

Answer the following questions, failure to answer all the questions makes your request incomplete, delaying the approval 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 location?

2) Is this a permanent or temporary request? What is the time frame for your request (provide specific dates)?

3) What are the hours of operation at each location?

Location #1	Location #2	Location # 3
WDDD#	WDDD#	WDDD#
Hours of operation:	Hours of operation:	Hours of operation:

4) How many hours will you work at each location? What days and times will you be present at each location?

5) **EXPERIENCE**- List work experience related to managerial experience where your responsibilities include, but are not limited to record keeping, warehousing, distributing, or other logistics services pertaining to prescription drug. Indicate how long you have been in the managerial role.

6) What is the nature of business at each location? Do any of these Wholesale locations sell directly to a Terminal Distributor of Dangerous Drugs (TDDD)?

Name of Location #1	Name of Location #2	Name of Location #3
WDDD #	WDDD#	WDDD#
Nature of Business:	Nature of Business:	Nature of Business:

Do any of these Wholesale locations sell directly to a prescriber office, hospital, or wholesaler?

7**) LICENSURE:** List all current state licenses and the type of license: (ex: wholesaler, third party logistic provider, virtual manufacture/wholesaler, broker, repackager, or VAWD accredited)

8) **INSPECTION:** List the licensed location name, WDDD#, recent inspection date, and inspecting agency

Location #1:	Location #2:	Location #3:
WDDD #:	WDDD #:	WDDD #:
Inspection Date:	Inspection date:	Inspection date:
Inspecting agency:	Inspecting agency:	Inspecting agency:
Corrective action needed (yes/no)	Corrective action needed (yes/no)	Corrective action needed (*yes/no)

Please submit a copy of the MOST RECENT inspection and/or VAWD accreditation along with any corrective action response that may have been submitted to the inspecting agency.

9) Is there a full-time operational manager or supervisor at each location other than yourself? If yes, list the name and title for each location. List how many employees are currently working at each location.

Location #1	Title	Manager/Supervisor Name
Location #2	Title	Manager/Supervisor Name
Location#3	Title	Manager/Supervisor Name

10) If wholesaling controlled substances, are you reporting to OARRS (Ohio Automated RX Reporting System)?

I attest that I have read OAC 4729-5-11 , meet and willcomply with the requirements of the rule(s) as set forth. The information provided is an accurate reflection of the activity for which approval is requested.

Print/Type Name of Responsible Person	Signature or Responsible Person	Date
Email Address	Phone Number (including area code)	

COMPLETED FORM MAY BE SCANNED AND EMAILED, FAXED, *OR* MAILED TO THE CONTACT INFORMATION IN ABOVELETTERHEAD.