Hours of Operation – Office Based Opioid Treatment Facilities

This form must be used to report any changes to the licensee's hours of operation as required by the Ohio Administrative Code. This form must be submitted by email to compliance@pharmacy.ohio.gov.

Business Name	**Terminal Distributor License Number**

HOURS OF OPERATION – Please indicate the hours the facility will be open to see patients (provide on a separate sheet if necessary).

Day of the Week	Open	Close	Open	Close
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Statement must be manually signed (**wet ink – NO COPIES**) and completed by licensee's responsible person.

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE INFORMATION PROVIDED ON THIS FORM IS **TRUE, CORRECT, AND COMPLETE.**	
Signature of Responsible Person (wet ink – NO COPIES)	**Date**
Responsible Person Name (please print)	

This form must be submitted by email to compliance@pharmacy.ohio.gov.