



PICK-UP STATION REQUEST FORM (1-many)

To be used when both the shipper and receiver are within the same corporation.

Corporate Pharmacy Name
Corporate Pharmacy Address
Ohio Terminal Distributor of Dangerous Drugs (TDDD) License Number(s) (attach a list if necessary)

Please provide the following information for each corporate location that will act as a Pick-up Station (attach a separate list if necessary):

Pick-Up Station #1

Name	TDDD Number
Address	
Responsible Person	
E-mail of Responsible Person	
Phone number of Responsible Person	
Professional License Number of Responsible Person	

Pick-Up Station #2

Name	TDDD Number
Address	
Responsible Person	
E-mail of Responsible Person	
Phone number of Responsible Person	
Professional License Number of Responsible Person	



Pick-Up Station #3

Name	TDDD Number
Address	
Responsible Person	
E-mail of Responsible Person	
Phone number of Responsible Person	
Professional License Number of Responsible Person	

Pick-Up Station #4

Name	TDDD Number
Address	
Responsible Person	
E-mail of Responsible Person	
Phone number of Responsible Person	
Professional License Number of Responsible Person	

Pick-Up Station #5

Name	TDDD Number
Address	
Responsible Person	
E-mail of Responsible Person	
Phone number of Responsible Person	
Professional License Number of Responsible Person	

Description of Activity

In the box below (or as a separate attachment), provide a narrative that includes the following: 1) a description of the activity that will be conducted; 2) a list of the types of drugs involved; and 3) information on how you will comply with the requirements of OAC 4729-5-10 (<http://codes.ohio.gov/oac/4729-5-10>). Either the pharmacy or the Pick-up Station can write the narrative. ***Failure to include the narrative will result in the automatic denial of your request.***

I attest that I have read OAC 4729-5-10 (<http://codes.ohio.gov/oac/4729-5-10>), my corporation meets and will comply with the requirements of this rule as set forth. The narrative provided is an accurate reflection of the activity that will be conducted.

Print/type name of responsible contact person at the corporation:	
Signature of responsible contact person at the corporation:	Date:
E-mail of responsible contact person at the corporation:	
Phone number of responsible contact person at corporation:	

THE COMPLETED FORM and ANY ATTACHMENTS MUST BE SCANNED AND UPLOADED AS A SINGLE PDF DOCUMENT HERE:

<http://www.pharmacy.ohio.gov/Licensing/GeneralDocumentUpload.aspx>