



RESPONSIBLE PERSON REQUEST FOR MORE THAN ONE PHARMACY TO BE LICENSED AS A TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS

PLEASE PRINT OR TYPE 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	Professional License Number (if applicable)	
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 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 of 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? 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) What is the nature and/or business at each location? Do either TDDD 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 Pharmacist work at each location? Provide their name, license member, and if they are full-time or Part-time.	
Pharmacy Location #1:	Pharmacy Location #2:
Pharmacist:	Pharmacist:

8) Are both locations utilizing and reporting to OARRS? If not, do you have an exemption?	
Pharmacy Location #1:	Pharmacy Location #2:
Reporting to OARRS:	Reporting to OARRS
Exempt:	Exempt:
Full name of Reporting Pharmacist:	Full Name of Reporting Pharmacist:
Delegates:	Delegates:

I attest that I have read [OAC 4729-5-11](#), meet and will comply 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 of 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 ABOVE LETTERHEAD.