Automated Pharmacy Systems Request Form

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

Part I – Licensee Information

Name of Licensee	**TDDD License No.**
Street Address	**Name of Responsible Pharmacist (RP)**
City	**RP Contact Phone (xxx-xxx-xxxx)**
Zip Code	**RP E-Mail Address**

NOTE: *If requesting approval of the same system at multiple locations, please append a list to this form of all licensed locations where you are seeking approval. The list and this form must be uploaded as one file.*

Part II – System Information

Name of System	**Manufacturer**
Requested Approval Date	
Pharmacist Final Verification: ◯ **The system will not require final verification (i.e., the final check) by a pharmacist.** *REMINDER: Each system that does not require final verification must submit accuracy metrics using a form developed by the Board. The form must be submitted by email to: compliance@pharmacy.ohio.gov.* ◯ **The system will be used to assist in the dispensing process, but all medications will be verified (i.e., the final check) by the pharmacist.**	
Briefly describe the intended use of the automated pharmacy system:	

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