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
Anticipated Implementation Date Approval Date	
Pharmacist Final Verification: **The system will <u>not</u> 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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