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 OAC 4729:5-2-01(D). 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.