Request to Hold an Office-Based Opioid Treatment Facility License and a Pain Management Clinic License

No applicant for a license as a terminal distributor of dangerous drugs with an office-based opioid treatment classification may also hold a license as a terminal distributor of dangerous drugs with a pain management clinic classification unless approved by the Board of Pharmacy.

Please be advised that requests will be presented to the Board for approval upon submission of a completed application, including the results of the required criminal records check for each owner.

The Board also reserves the right to request additional information from an applicant to determine if granting a license is in the public's interest.

To be considered for approval, this form must be submitted with an initial application in the eLicense system.

PAIN MANAGEMENT CLINIC INFORMATION

If more than two, please include information on a separate piece of paper and sign the statement included on this form.

Business Name (i.e. reflected by signage/how you will answer phone)			**County**
Street Address (No P.O. Box)	**City, State**	**Zip Code**	**Phone (include area code)**
Terminal Distributor Number		**Name of Responsible Person on the License**	

Business Name (i.e. reflected by signage/how you will answer phone)			**County**
Street Address (No P.O. Box)	**City, State**	**Zip Code**	**Phone (include area code)**
Terminal Distributor Number		**Name of Responsible Person on the License**	

NAME OF PHYSICIAN OWNER(S) OF THE TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS WITH A PAIN MANAGEMENT CLINIC CLASSIFICATION

If more than FOUR, please include information on a separate piece of paper and sign the statement included on this page.

Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No.**
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*Statement must be manually signed (**wet ink – NO COPIES**) and completed by the individual who may legally sign for the business and can verify the information provided in this application is true, correct, and complete. Failure to do so makes your application incomplete, delaying the licensing process.*

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE ANSWERS PROVIDED ON THIS FORM AND IN THE ONLINE APPLICATION SUBMITTED TO THE STATE BOARD OF PHARMACY ARE **TRUE, CORRECT, AND COMPLETE.**	
Signature of Applicant (wet ink – NO COPIES)	**Date**
Applicant Name (please print)	