Steven W. Schierholt, Esq.
Executive Director

John R. Kasich
Governor

STATE OF OHIO BOARD OF PHARMACY

APPLICATION FOR OFFICE-BASED OPIOID TREATMENT

Failure to complete all required fields, provide necessary supplemental documentation and correct fee will delay the application process. If a question is not applicable, answer as N/A.

APPLICATION FEE FOR A CATEGORY III TERMINAL DISTRIBUTOR LICENSE WITH AN OFFICE-BASED OPIOID TREATMENT CLASSIFICATION IS $150.00.

Please make check payable to "Treasurer, State of Ohio"

APPLICATION AND PAYMENT SHOULD BE MAILED TO: 77 SOUTH HIGH STREET, 17th FLOOR, COLUMBUS, OHIO 43215

THIS APPLICATION IS FOR A FACILITY, CLINIC, OR OTHER LOCATION WHERE A PRESCRIBER PROVIDES OFFICE-BASED OPIOID TREATMENT TO MORE THAN THIRTY PATIENTS AT ANY ONE TIME, UNLESS THE FACILITY IS EXEMPTED. THE LICENSE IS REQUIRED EVEN IF NO DRUGS ARE ON-SITE.

EXEMPTIONS FROM LICENSURE

Be advised, the following are excluded from the office-based opioid treatment licensing requirements:

(1) A facility or clinic where a prescriber(s) provides office-based opioid treatment to thirty or fewer patients at any one time;

(2) Hospitals;

(3) Facilities for the treatment of opioid dependence or addiction that are operated by a hospital;

(4) Physician practices owned or controlled, in whole or in part, by a hospital or an entity that owns or controls, in whole or in part, one or more hospitals;

(5) Facilities that only conduct clinical research and use controlled substances in studies approved by a hospital-based institutional review board or an institutional review board that is accredited by the Association for the Accreditation of Human Research Protections Programs, Inc.;

(6) Facilities that hold a category III terminal distributor of dangerous drugs license for the purpose of treating drug dependence or addiction as part of an opioid treatment program and are already subject to certification by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA); or

(7) Programs or facilities that are licensed or certified by the Ohio Department of Mental Health and Addiction Services.

Rules pertaining to licensure can be accessed by visiting: www.pharmacy.ohio.gov/OBOTrules

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OFFICE-BASED OPIOID TREATMENT (OBOT) APPLICATION CHECKLIST

Please review all rules relating to licensure by visiting: www.pharmacy.ohio.gov/OBOTrules

All of the following documents must be sent with the Terminal Distributor of Dangerous Drug (TDDD) application. If any item is not submitted, the application is considered incomplete and cannot be processed.

☐ **Complete application and $150.00 application fee.**

- Please make check or money order payable to "Treasurer, State of Ohio"
- Application must include original wet-ink signatures. No copies will be accepted.

☐ **Corporations must attach a copy of articles of incorporation; limited liability companies must attach a copy of articles of organization or certificate of formation.**

- These documents may be contained in the business files usually maintained by the applicant's business office or respective Secretary of State. For Ohio entities, visit www.sos.state.oh.us.

☐ **Ownership Criminal Records Check Form**

☐ **For applicants that include non-physician owners: The Request for Exemption from Physician Ownership Requirement Form**

- The form is included with this application.
- This form should also be submitted if the owner is a physician but is **not** currently licensed in the State Medical Board of Ohio.

☐ **For applicants that currently hold a Pain Management Clinic license from the Board of Pharmacy: The Request to Hold an Office-Based Opioid Treatment Facility License and a Pain Management Clinic License Form**

- The form is included with this application.

OFFICE-BASED OPIOID TREATMENT (OBOT) CRIMINAL RECORDS CHECK REQUIREMENTS

All of the following must be completed at the time of application submission:

☐ **BCI&I and FBI background check for each owner*, pursuant to ORC section 4776.02.**

- Please be advised that criminal records checks may take between 6-8 weeks to process.
- You will need to submit your electronic fingerprint impressions at a WebCheck provider located in Ohio. WebCheck provider locations can be found at: http://www.ohioattorneygeneral.gov/Business-and-Non-Profits/Business/Webcheck/Webcheck-Community-Listing
- Direct the results to be sent directly to State of Ohio Board of Pharmacy, 77 S. High Street, 17th Floor, Columbus, Ohio 43215.
- Indicate the reason for fingerprinting is Ohio Revised Code Section 4729.071 for Licensing.
- Give them Agency Code: 1AB002
- *Note: WebCheck provider must submit results of the criminal records check directly to the State of Ohio Board of Pharmacy for review and decision pursuant to ORC 4729.071 and 4729.553.*

*Please review rule 4729-18-03 for more information on who is required to submit to a background check.

☐ **BCI&I and FBI background check for all employees, pursuant to ORC section 4776.02.**

Reminder: All employees of the OBOT applicant must submit to a criminal records check in accordance with ORC sections 4729.553(D)(4) and 4776.02. These results are to be returned to the OBOT applicant, **NOT** to Board or the employee. If these records are not available, the license will NOT be issued when Board agents perform their initial inspection and may result in a delay and possible denial of your license. Please refer to rule 4729-18-03 for more information. Please be advised that criminal records checks may take between 6-8 weeks to process.

Section 4729.553 of the Ohio Revised Code prohibits the employment of any individual at a licensed OBOT facility who has previously been convicted of, or pleaded guilty to, either of the following:

- A theft offense, described in division (K)(3) of section 2913.01 of the Revised Code, that would constitute a felony under the laws of this state, any other state, or the United States;
- A felony drug offense, as defined in section 2925.01 of the Revised Code.

Steven W. Schierholt, Esq.
Executive Director

STATE OF OHIO BOARD OF PHARMACY

John R. Kasich
Governor

OFFICE-BASED OPIOID TREATMENT FACILITY
TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS

CAREFULLY READ ALL INSTRUCTIONS. Failure to complete all fields, provide necessary supplemental documentation and correct fee will delay the application process. If a question is not applicable, answer as N/A.

Application fee is $150.00.

Please make check payable to "Treasurer, State of Ohio"

APPLICATION AND PAYMENT SHOULD BE MAILED TO: 77 SOUTH HIGH STREET, 17TH FLOOR, COLUMBUS, OH 43215

PLEASE TYPE OR PRINT LEGIBLY

1. LICENSE REQUEST

☐ Change ☐ New	Proposed opening date or date of change (or indicate facility is currently open)	If change, give current TDDD License Number
If change, select ***ALL*** that apply: ☐ Name ☐ Ownership ☐ Business Type (if currently licensed as a terminal distributor of dangerous drugs.)		

2. NAME, ADDRESS AND PHONE NUMBER OF BUSINESS BEING LICENSED

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)
Mailing Address, City, State, Zip Code (if different from above)			Fax (include area code)

3. INDIVIDUAL TO CONTACT REGARDING ABOVE LOCATION, BETWEEN 8 AM AND 5 PM WEEKDAYS - Individual to contact if there are questions regarding the application (must be the Responsible Person or designee) and the person who will receive your Ohio license.

Name	Title
E-mail	Phone (include area code)

For State of Ohio Board of Pharmacy Use Only						
Control #	Amt Received	Office/Field	Class	BT	Drug Category III	TDDD License New # Same #

4. APPLICANT INTENDS DOING BUSINESS AS (*Select One*) - Indicate the applicant's type of business organization

☐ Government	☐ Corporation	☐ Partnership	☐ Limited Liability Company
☐ Sole Proprietorship			

4a. NAME OF GOVERNMENT AGENCY (if applicable)

Name

4b. OWNERSHIP INFORMATION – Corporations must attach a copy of articles of incorporation; limited liability companies must attach a copy of articles of organization or certificate of formation. These documents may be contained in the business files usually maintained by the applicant's business office or the Ohio Secretary of State (www.sos.state.oh.us).

Leave blank if Government Agency

Entity/Charter number	Federal Tax ID or EIN Number	State where incorporated

4c. NAME OF PHYSICIAN OWNER(S) – If requesting a waiver from this requirement, check the box below, complete the exemption request form included with this application and leave this question blank.

Leave blank if Government Agency

Name	Ohio Medical Board License Number	Date of Birth or Social Security Number
Name	Ohio Medical Board License Number	Date of Birth or Social Security Number
Name	Ohio Medical Board License Number	Date of Birth or Social Security Number

If more than THREE physician owners, please include information on a separate piece of paper.

I am requesting an exemption from the physician ownership requirements in section 4729.553 ORC.

5. HAS THE ENTITY EVER BEEN DENIED A LICENSE OR REQUESTED TO WITHDRAW OR HAS IT WITHDRAWN AN APPLICATION FOR LICENSURE IN THIS OR ANY OTHER STATE?

☐ Yes ☐ No	If yes, please provide the name of the licensing agency and approximate date of application and the reason why:

6. CATEGORY III LICENSE - Application is hereby made for a license as a CATEGORY III TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS WITH AN OFFICE-BASED OPIOID TREATMENT CLASSIFICATION. This licensee may possess, have custody or control of, and distribute prescription drugs, including controlled substances contained in Schedules II, III, IV, or V.

DOES THE APPLICANT PLAN TO STORE CONTROLLED SUBSTANCE MEDICATIONS ON-SITE?

☐ Yes ☐ No	If yes, provide the ordering prescriber's Drug Enforcement Administration License Number:

7. DOES ANY PRESCRIBER AT THE FACILITY OR CLINIC PLAN TO TREAT (i.e. PRESCRIBE OR PERSONALLY FURNISH) MORE THAN 30 PATIENTS FOR OPIOID ADDICTION OR DEPENDENCE WITH A CONTROLLED SUBSTANCE?

☐ Yes ☐ No	If no, licensure is **not** necessary. Please refer to exemption (1) on the front page of the application.

7b. WILL ANY DANGEROUS DRUGS (i.e. PRESCRIPTION DRUGS) BE PHYSICALLY STORED ON-SITE?

☐ Yes ☐ No	If yes, provide a brief description of the type of prescription medications stored on-site.

7c. DOES THE APPLICANT ALSO POSSESS A LICENSE AS A TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS WITH A PAIN MANAGEMENT CLINIC CLASSIFICATION (ORC 4729.552)?

☐ Yes ☐ No	If yes, the applicant must submit the request form entitled "Request to Hold an Office-Based Opioid Treatment Facility License and a Pain Management Clinic License" that is included with this application.

7d. PROVIDE A NARRATIVE DESCRIPTION OF THE TYPE OF BUSINESS ACTIVITIES (PLEASE BE SPECIFIC) THAT WILL BE CONDUCTED AT THIS LOCATION THAT REQUIRES THE APPLICANT TO BE ISSUED A TDDD LICENSE - Provide on a separate sheet if necessary.

Indicate your web site address *(if applicable)*, and type of business being conducting in Ohio.
A narrative must be provided or the application is considered incomplete.

Examples: Describe the type of services offered at this facility.

7e. 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				

NOTE: Licensees must report changes in hours of operation to the Board within 3 business days. For more information, please go to: www.pharmacy.ohio.gov/OBOThours

8. APPLICANT LEGAL AND DISCIPLINARY QUESTIONS – Failure to answer the following questions makes your application incomplete, delaying the licensing process. Answering incorrectly could be a violation of Ohio law, see ORC 4729.57 and 2921.13.

Please note that **Applicant** includes all the following (when applicable):

- The business entity
- Owner
- Operator
- Corporate officers, including: president, vice president, secretary, treasurer, CEO, CFO, or any equivalent position
- Partner(s)
- Sole proprietor
- Employees responsible for the provision of patient care at the facility (this includes contract prescribers and other healthcare professionals)
- Any other person with access to drug stock*

*Access to drug stock includes not only physical access, but also any influence over the handling of prescription drugs (i.e. dangerous drugs) such as purchases, inventories, issuance of medical orders, etc. It does not include employees/contractors such as maintenance, janitorial, IT or other staff that may need limited supervised access to areas where prescription drugs or D.E.A. controlled substance order forms are kept.

For more information on answering the legal/disciplinary questions, visit: www.pharmacy.ohio.gov/legalOBOT

****If the answer to any of the following questions is yes, include the person's title, duties, and responsibilities, a detailed account (including date, place, circumstances, and disposition of the matter), and copies of relevant documents (such as court pleadings or orders, or other agency orders/dispositions)****

8a. Has the applicant ever been convicted of, or are there charges pending for, a felony or misdemeanor drug offense under state or federal law?

- This includes a court granting intervention in lieu of treatment (also known as treatment in lieu of conviction, ILC or TLC), or other diversion programs.
- Felony or misdemeanor drug offenses must be included regardless of whether the case has been expunged or sealed or the equivalent thereof. *This applies to question 8a only*.
- Note: Minor misdemeanor drug convictions *are not* required to be reported. ORC 2925.11(D).

☐ **Yes** ☐ **No**

8b. Has the applicant ever been convicted of, or are there charges pending for, any other felony under state or federal law?

☐ **Yes** ☐ **No**

8c. Within the past 10 years, has the applicant ever been convicted of, or are there charges pending for, a misdemeanor theft offense as described in division (K)(3) of section 2913.01 of the Ohio Revised Code.

☐ **Yes** ☐ **No**

8d. Has the applicant ever been excluded or directed to be excluded from participation in a Medicare or state health care program, or is any such action pending?

☐ **Yes** ☐ **No**

8e. Has the applicant ever been denied a license by the Drug Enforcement Administration or appropriate issuing body of any state or jurisdiction, or is any such action pending?

☐ **Yes** ☐ **No**

8f. Has the applicant ever been the subject of an investigation or disciplinary action by the Drug Enforcement Administration or appropriate issuing body of any state or jurisdiction that resulted in the surrender, suspension, revocation, or probation of the applicant's license or registration?

☐ **Yes** ☐ **No**

8g. Has the applicant ever been the subject of a disciplinary action by the Drug Enforcement Administration or appropriate issuing body of any state or jurisdiction that was based in whole or in part, on the applicant's prescribing, dispensing, diverting, administering, storing, personally furnishing, compounding, supplying or selling a controlled substance or other dangerous drug (i.e. prescription drug), or is any such action pending?

☐ **Yes** ☐ **No**

****If the answer to any of the following questions is yes, include the person's title, duties, and responsibilities, a detailed account (including date, place, circumstances, and disposition of the matter), and copies of relevant documents (such as court pleadings or orders or other agency orders/dispositions)****

For more information on answering the legal/disciplinary questions, visit: www.pharmacy.ohio.gov/legalOBOT

9. RESPONSIBLE PERSON LEGAL AND DISCIPLINARY QUESTIONS - Failure to answer the following questions makes your application incomplete, delaying the licensing process. Answering incorrectly could be a violation of Ohio law, see ORC 4729.57 and 2921.13.

In accordance with rule 4729-18-02 of the Administrative Code, the responsible person is responsible for compliance with all state and federal laws, regulations, and rules regulating the operation of an office-based opioid treatment facility and the prescribing of controlled substances.

For more information on answering the legal/disciplinary questions, visit: www.pharmacy.ohio.gov/legalOBOT

****If the answer to any of the following questions is yes, include the person's title, duties, and responsibilities, a detailed account (including date, place, circumstances, and disposition of the matter), and copies of relevant documents (such as court pleadings or orders, or other agency orders/dispositions)****

9a. Has the responsible person ever been convicted of, or are there charges pending for, a felony or misdemeanor drug offense under state or federal law?

- This includes a court granting intervention in lieu of treatment (also known as treatment in lieu of conviction, ILC or TLC), or other diversion programs.
- Felony or misdemeanor drug offenses must be included regardless of whether the case has been expunged or sealed or the equivalent thereof.
- Note: Minor misdemeanor drug convictions *are not* required to be reported. ORC 2925.11(D).

☐ **Yes** ☐ **No**

9b. Has the responsible person ever been convicted of, or are there charges pending for, any other felony under state or federal law?

☐ **Yes** ☐ **No**

9c. Within the past 10 years, has the responsible person ever been convicted of, or are there charges pending for, a misdemeanor theft offense as described in division (K)(3) of section 2913.01 of the Ohio Revised Code.

☐ **Yes** ☐ **No**

9d. Has the responsible person ever been convicted of, or are there charges pending for, a misdemeanor related to, or committed in, the practice of medicine?

☐ **Yes** ☐ **No**

9e. Has the responsible person ever been convicted of, or are there charges pending for, a crime of moral turpitude as defined in section 4776.10 of the Ohio Revised Code?

☐ **Yes** ☐ **No**

9f. Has the responsible person ever been convicted of, or are there charges pending for, a crime (felony or misdemeanor) involving an act of moral turpitude?

☐ **Yes** ☐ **No**

9g. Has the responsible person ever been excluded or directed to be excluded from participation in a Medicare or state health care program, or is any such action pending?

☐ **Yes** ☐ **No**

9h. Has the responsible person ever been denied a license by the Drug Enforcement Administration or appropriate issuing body of any state or jurisdiction, or is any such action pending?

☐ **Yes** ☐ **No**

9i. Has the responsible person ever been the subject of an investigation or disciplinary action by the Drug Enforcement Administration or appropriate issuing body of any state or jurisdiction that resulted in the surrender, suspension, revocation, or probation of the responsible person's license or registration?

☐ **Yes** ☐ **No**

9j. Has the responsible person ever been the subject of a disciplinary action by the Drug Enforcement Administration or appropriate issuing body of any state or jurisdiction that was based in whole or in part, on the responsible person's prescribing, dispensing, diverting, administering, storing, personally furnishing, compounding, supplying or selling a controlled substance or other dangerous drug (i.e. prescription drug), or is any such action pending?

☐ **Yes** ☐ **No**

10. LIST OF PRESCRIBERS PRACTICING AT THE FACILITY – Please provide a complete list of all prescribers currently practicing at the facility at the time of application. This includes all prescribers (MD/DO, APRN, PA, etc.) even if they are not treating patients for opioid dependence or addiction and all contract prescribers working at the facility.

Name of Prescriber	Type of Prescriber (MD/DO, APRN, PA, etc.)	Ohio Professional License Number

If necessary, continue using a separate sheet of paper.

11. STATEMENT OF APPLICANT (Person who may legally sign for the business)

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.

Name	Title	
Phone (include area code)	E-mail	
I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921., 3715., 3719. AND 4729. OF THE OHIO REVISED CODE THAT I AM AUTHORIZED TO PURSUE THIS APPLICATION ON BEHALF OF THE ENTITY LISTED IN THIS APPLICATION AND THAT THIS APPLICATION IS **TRUE, CORRECT, AND COMPLETE**. I HEREBY ACKNOWLEDGE THAT IF THE LICENSE APPLIED FOR IS GRANTED, THE LICENSE-HOLDER SHALL SUBMIT TO THE JURISDICTION OF THE STATE OF OHIO BOARD OF PHARMACY AND TO THE LAWS OF THIS STATE FOR THE PURPOSE OF ENFORCEMENT OF CHAPTERS 2925., 3715., 3719. AND 4729. OF THE OHIO REVISED CODE AND ALL RELATED LAWS AND RULES. I FULLY UNDERSTAND THAT SUBMISSION OF THIS APPLICATION WITH THE STATE BOARD OF PHARMACY CONSTITUTES PERMISSION FOR ENTRY AND ON-SITE INSPECTION BY AN AUTHORIZED BOARD AGENT IN ACCORDANCE WITH RULE 4729-9-09 OF THE OHIO ADMINISTRATIVE CODE.		
Signature of Applicant	**Date**	**Date of Birth or Social Security Number**

12. STATEMENT OF PHYSICIAN RESPONSIBLE FOR COMPLIANCE WITH OHIO LAW AND RULES (RESPONSIBLE PERSON)

OAC 4729-18-02 REQUIRES THE RESPONSIBLE PERSON OF AN OFFICE-BASED OPIOID TREATMENT FACILITY TO MEET THE FOLLOWING REQUIREMENTS:

- The physician is authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.
- The physician possesses a waiver to prescribe or personally furnish buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000).
- A physician shall not be designated the responsible person for a location licensed as a category III terminal distributor of dangerous drugs with an office-based opioid treatment classification unless the physician will be physically present at the location for at least **fifteen hours** per week. If the facility is not open more than fifteen hours per week, the minimum amount of on-site supervision shall be at least fifty percent of the total hours the facility is open, as reported to the board by the licensee on the application (see question 7e).

UNLESS OTHERWISE APPROVED BY THE BOARD, NO RESPONSIBLE PERSON FOR A LOCATION LICENSED AS A CATEGORY III TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS WITH AN OFFICE-BASED OPIOID TREATMENT CLASSIFICATION UNDER SECTION 4729.553 OF THE OHIO REVISED CODE SHALL:

(a) Have ever been denied a license to prescribe, dispense, personally furnish, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on the prescriber's inappropriate prescribing, dispensing, administering, personally furnishing, diverting, supplying or selling a controlled substance or other dangerous drug.

(b) Have been the subject of any of the following by the drug enforcement administration, the substance abuse and mental health services administration or licensing agency of any state or jurisdiction:

(i) A disciplinary action that resulted in the suspension or revocation of the physician's license, registration or DATA 2000 waiver; or

(ii) A disciplinary action that was based, in whole or in part, on the physician's inappropriate prescribing, personally furnishing, diverting, administering, storing, compounding, supplying or selling a controlled substance or other dangerous drug; or

(iii) Surrender of any license or registration in lieu of disciplinary action.

(c) Have been convicted of any of the following:

(i) a felony;

(ii) a misdemeanor related to, or committed in, the practice of medicine; or

(iii) an act of moral turpitude; or

(iv) a crime of moral turpitude as defined in section 4776.10 of the Revised Code.

If the responsible person on the application has any of the disciplinary actions or criminal convictions listed above and is seeking approval from the Board, please provide a request by the responsible person that includes a detailed account (including date, place, circumstances, and disposition of the matter) and copies of relevant documents (such as court pleadings or orders, or other agency orders/dispositions) with this application.

The Responsible Person statement must be signed (**wet ink – NO COPIES**) and dated by the individual who will be responsible for compliance with all state and federal laws, regulations, and rules regulating the operation of an office-based opioid treatment facility and prescribing of controlled substances (i.e. the Responsible Person).

The Responsible Person is also responsible for ensuring that the application is true, correct and complete.

I HEREBY AGREE to and assume the responsibility for compliance with all state and federal laws, regulations, and rules regulating the operation of a terminal distributor of dangerous drugs and the prescribing of controlled substances for the applicant pursuant to rule 4729-18-02 of the Ohio Administrative Code.

I HEREBY AGREE to and assume the responsibility for supervision and control over the possession and custody of the dangerous drugs and drug records that may be acquired/maintained by, or on behalf of, the applicant pursuant to section 4729.55(B) of the Ohio Revised Code.

I FULLY UNDERSTAND that, as a licensed Terminal Distributor, drugs may be purchased only within the requested category of license from Wholesale Distributors of Dangerous Drugs registered in the state of Ohio by the State of Ohio Board of Pharmacy. I also understand that if, or when, this business is discontinued that a "Written Notice of Discontinuing Business" form must be secured from the State of Ohio Board of Pharmacy, completed by me, and returned to the Board's office as required by rule 4729-9-07 of the Ohio Administrative Code.

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921., 3715., 3719. AND 4729. OF THE OHIO REVISED CODE THAT I AM AUTHORIZED TO PURSUE THIS APPLICATION ON BEHALF OF THE ENTITY LISTED IN THIS APPLICATION AND THAT THIS APPLICATION IS **TRUE, CORRECT, AND COMPLETE**. I HEREBY ACKNOWLEDGE THAT IF THE LICENSE APPLIED FOR IS GRANTED, THE LICENSE-HOLDER AND I SHALL SUBMIT TO THE JURISDICTION OF THE STATE OF OHIO BOARD OF PHARMACY AND TO THE LAWS OF THIS STATE FOR THE PURPOSE OF ENFORCEMENT OF CHAPTERS 2925., 3715., 3719. AND 4729. OF THE OHIO REVISED CODE AND ALL RELATED LAWS AND RULES.

SIGNATURE of Responsible Person	**Date Signed**	**PRINT OR TYPE NAME**

Phone (include area code)	E-mail Address

Ohio Medical Board License Number	DEA Registration (i.e. "X number")

COMPLETION OF THIS FORM IS REQUIRED BY O.R.C. SECTION 4729.553
MAXIMUM PENALTY: DENIAL OF LICENSE

Steven W. Schierholt, Esq.
Executive Director

John R. Kasich
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STATE OF OHIO BOARD OF PHARMACY

Ownership Criminal Records Check Form

This form **must** be submitted with the application. Failure to submit this form with the application will delay the licensing process.

PLEASE NOTE: IT MAY TAKE 6-8 WEEKS TO PROCESS A CRIMINAL RECORDS CHECK.

Provide Name of Applicant's Business	

Please provide the full legal name (no nicknames), the Webcheck® agency where OBOT facility owners have submitted fingerprints for a criminal records check and the date the fingerprints were submitted.

Owner First Name	Owner Last Name	Webcheck® Agency	Date Fingerprints Submitted

Use Additional Form if Necessary

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Request for Exemption from Physician Ownership Requirement

Section 4729.553 requires a terminal distributor of dangerous drugs with an office-based opioid treatment classification to be operated solely by one or more physicians authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery, **unless** the state board of pharmacy has exempted the holder from this requirement.

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.

Pursuant to rule 4729-18-02, in reviewing the exemption request, the Board will consider, at a minimum, all the following:

1) The results of criminal records checks conducted in accordance with rule 4729-18-03 of the Administrative Code;

2) The results of a pre-inspection authorized in accordance with rule 4729-9-09 of the Administrative Code, including compliance with rule 4729-18-04 of the Administrative Code;

3) A review of any past disciplinary actions taken against any owner that are based, in whole or in part, on the professional's inappropriate prescribing, personally furnishing, diverting, administering, storing, compounding, supplying or selling a controlled substance or other dangerous drug; and

4) Commission of an act by any owner that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed.

NOTE: Previous disciplinary action or criminal convictions do not automatically disqualify a facility from obtaining an exemption. The Board is responsible for reviewing the facts and circumstances related to an exemption request to determine its potential connection, if any, to the issuance of a license. The purpose of such review is to act as a safeguard against the diversion of dangerous drugs to protect the health and safety of the public.

Please be advised, the Board reserves the right to request additional information from an applicant to determine if granting a license is in the public's interest.

An applicant whose request is denied by the board will be provided with a written explanation of the denial and allowed one opportunity to resubmit its request to address the identified concerns. The resubmission of the request shall occur within sixty days of receiving the board's written explanation or the application will be deemed abandoned in accordance with rule 4729-9-01 of the Administrative Code.

To be considered for an exemption of this requirement, please submit the following information with the licensure application.

<u>REQUEST FOR EXEMPTION FROM PHYSICIAN OWNERSHIP REQUIREMENT</u>

NAME OF ALL OWNER(S)*

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

Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No. and Name of Licensing Agency (if applicable)**
Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No. and Name of Licensing Agency (if applicable)**
Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No. and Name of Licensing Agency (if applicable)**
Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No. and Name of Licensing Agency (if applicable)**
Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No. and Name of Licensing Agency (if applicable)**
Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No. and Name of Licensing Agency (if applicable)**
Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No. and Name of Licensing Agency (if applicable)**

**For a corporation, the following individuals must be listed: The president, vice president, secretary, treasurer, and chief executive officer, or any equivalent position of a corporation and, if a corporation is not publicly traded on a major stock exchange, each shareholder owning ten percent or more of the voting stock of the corporation.*

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 HEREBY REQUST AN EXEMPTION PURSUANT TO 4729.553 (D)(1) OF THE OHIO REVISED CODE.

I HEREBY ACKNOWLEDGE THAT SUBMISSION OF AN APPLICATION FOR A LICENSE OR REGISTRATION WITH THE STATE BOARD OF PHARMACY CONSTITUTES PERMISSION FOR ENTRY AND ON-SITE INSPECTION BY AN AUTHORIZED BOARD AGENT PURSUANT TO RULE 4729-9-09 OF THE OHIO ADMINISTRATIVE CODE.

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921., 3715., 3719. AND 4729. OF THE OHIO REVISED CODE THAT I AM AUTHORIZED TO PURSUE THIS APPLICATION ON BEHALF OF THE ENTITY LISTED IN THIS APPLICATION AND THAT THIS APPLICATION IS **TRUE, CORRECT, AND COMPLETE**.

Signature of Applicant (wet ink – NO COPIES)	**Date**

Applicant Name (please print)

Steven W. Schierholt, Esq.
Executive Director

John R. Kasich
Governor

STATE OF OHIO BOARD OF PHARMACY

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

Pursuant to rule 4729-18-02, 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, please submit the following information with the licensure application.

PAIN MANAGEMENT CLINIC INFORMATION

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

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 TWO, 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. and Name of Licensing Agency (if applicable)**
Name	**Title**	**Date of Birth or Social Security No.**	**Professional License No. and Name of Licensing Agency (if applicable)**

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 HEREBY REQUST AN APPROVAL PURSUANT TO PARAGRAPH (D) OF RULE 4729-18-02 OF THE OHIO ADMINISTRATIVE CODE.

I HEREBY ACKNOWLEDGE THAT SUBMISSION OF AN APPLICATION FOR A LICENSE OR REGISTRATION WITH THE STATE BOARD OF PHARMACY CONSTITUTES PERMISSION FOR ENTRY AND ON-SITE INSPECTION BY AN AUTHORIZED BOARD AGENT PURSUANT TO RULE 4729-9-09 OF THE OHIO ADMINISTRATIVE CODE.

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921., 3715., 3719. AND 4729. OF THE OHIO REVISED CODE THAT I AM AUTHORIZED TO PURSUE THIS APPLICATION ON BEHALF OF THE ENTITY LISTED IN THIS APPLICATION AND THAT THIS APPLICATION IS **TRUE, CORRECT, AND COMPLETE**.

Signature of Applicant (wet ink – NO COPIES)	**Date**
Applicant Name (please print)	