APPLICATION FOR LIMITED LICENSE AS A TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS WITH AN E.M.S. CLASSIFICATION

INSTRUCTIONS

COMPLETE BOTH PAGES OF FORM # 0600 WITH ORIGINAL SIGNATURES
SEND TO THE BOARD OFFICE WITH ALL OTHER REQUIRED DOCUMENTS AND THE CORRECT FEE (see instruction #9)
WITHOUT FEE, ENTIRE APPLICATION WILL BE RETURNED
MAKE CHECK PAYABLE TO "Treasurer, State of Ohio"

FORM # 0600 - Application for Terminal Distributor (TDDD) License

1. Indicate whether this application represents a new license or if this is a change to a current license. In the next box, give the proposed date of opening or licensing change. If this site is already open and not a licensed facility, indicate "already open". If a change, mark the type of change(s) which is/are occurring and give the existing TDDD license #, if applicable. This number begins with "02".
2. Must be completed with the name under which this applicant will be doing business (i.e., reflected by signage/how your staff will answer the phone) and the complete street address of the physical location where the drugs will be stored, including suite # if appropriate. This is what will appear on the license. Do NOT use a P.O. Box. Please enter the phone number of this location (indicate if phone number has not been assigned yet). The address submitted on the application must describe only one establishment or place where the licensee will engage in the sale or distribution of dangerous drugs. If you desire a different mailing address (i.e., for license renewals), place it in the mailing address box. You can use a P.O. Box here if desired. If you want all mail to the attention of someone in addition to the Responsible Person, please do not use that specific person's name but indicate by title or department name.
3. If the applicant will conduct business under any other name, please list the name(s).
4. Enter information for the individual to contact if there are questions regarding the application.
5. For contingency stock licenses only: This is not relevant to EMS. Leave this blank.

If needed, the information requested in 6, 6a, 6b, and 6c will be contained in corporation papers usually maintained by the applicant's business office.

6. Indicate the type of business organization the applicant intends doing business as.

6a. Give the name(s) of the individual(s) who is/are the owner(s) or, if incorporated, the officers of the location being licensed.

6b. Pertains to government agencies only.

6c. If incorporated, indicate the type of corporation, the State of incorporation, and the Charter or filing number. In Ohio, you will find the chapters in your articles of incorporation. In other

states, you may need to look elsewhere. If you are having trouble obtaining your articles of incorporation, contact the Secretary of State. You are required to submit a copy of your articles of incorporation or LLC papers with the application. Failure to do so makes your application incomplete, delaying the licensing process.

7. Enter the trade, corporate, or partnership name and address of the business (owner of the location to be licensed).

8. List any other Ohio TDDD or WDDD license number(s) that the business owner holds (same or different locations). These will begin with "01" or "02".

9. Category of License (check only one). Indicate the correct category based on the drugs your facility will acquire and possess. Fee that must be submitted with the application is listed below, as set by law pursuant to ORC 4729.54.

   LIMITED CATEGORY I - $45.00 *This licensee may only possess, have custody or control of, and distribute drugs in Category I that the Medical Advisor has approved.* ***An addendum will be produced as part of the license, listing the drugs that have been submitted.***

   LIMITED CATEGORY II - $112.50 *This licensee may only possess, have custody or control of, and distribute drugs in Category II that the Medical Advisor has approved.* ***An addendum will be produced as part of the license, listing the drugs that have been submitted.***

   LIMITED CATEGORY III - $150.00 *This licensee may only possess, have custody or control of, and distribute drugs in Category III that the Medical Advisor has approved.* ***An addendum will be produced as part of the license, listing the drugs that have been submitted.***

   Remember an EMS organization…shall file a new application…if there is ANY change in the number, or location of, any of its units or any change in the category of the dangerous drugs that any unit will possess. ORC 4729.54(C)(2)

10. Indicate the type of establishment being licensed. It will be either "EMS-Headquarters" or "EMS-Satellite" found in the 3rd column from the left. In addition,

    all applicants must provide on a separate paper (i.e., business letterhead) a narrative description of the type of business activities (be specific!) that will be conducted at this location that require the applicant to be issued a TDDD license. Failure to do so makes your application incomplete, delaying the licensing process.

11 & 12. The legal questions must be answered. Please note these questions pertain to all of the following: the applicant (business at that location), the owner(s), the Responsible Person, any agent, and any employee - at this specific location. This would apply to the same business at a previous location on a change of address application, but not for every location in a corporation. Failure to answer these questions make your application incomplete, delaying the licensing process. Answering incorrectly could be a crime, see ORC 2921.13.

13. Statement *must be manually signed* (wet ink) 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.

14. Statement *must be signed* (wet ink) and dated by the individual who will be responsible for the supervision and control of the dangerous drugs and drug records at this location. Note: the Responsible Person (RP) is also responsible for ensuring that the application is true, correct, and complete. Enter all information requested in this section. The individual responsible for supervision and control of dangerous drugs and drug records for EMS must be an Ohio licensed physician or pharmacist. Failure of the Responsible Person to sign & complete this section of the application makes your application incomplete, delaying the licensing process.

OHIO STATE BOARD OF PHARMACY 77 SOUTH HIGH STREET, ROOM 1702 COLUMBUS, OHIO 43215-6126
Tel: 614-466-4143 *Fax*: 614-752-4836 *Email:* licensing@bop.ohio.gov *Website:* www.pharmacy.ohio.gov

TERMINAL DISTRIBUTOR OF DANGEROUS DRUGS — FORM # 0600

❶ Complete the form, print your DOB or SSN, sign, and date ❷ Make a copy for your file **TYPE OR PRINT LEGIBLY**

READ CAREFULLY ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION

1. LICENSE REQUEST FOR

☐NEW ☐ CHANGE	Proposed Opening Date or Date of Change	Change of ☐ Name ☐ Address ☐ Ownership ☐ New Satellite ☐ Category ☐ Other-specify ____________	If Change, give current TDDD License # 02

2. LOCATION BEING LICENSED

NAME the applicant will be DOING BUSINESS AS (i.e., reflected by signage/how you will answer phone)	County
Street Address, City, State, Zip Code (No P.O. Box)	Area Code / phone # Ext
Mailing Address, City, State, Zip Code (if different from above)	Area Code / Fax #

3. LIST ANY OTHER NAMES THE ENTITY WILL BE CONDUCTING BUSINESS UNDER (Attach separate sheet if necessary)

4. INDIVIDUAL TO CONTACT REGARDING ABOVE LOCATION, BETWEEN 8 AM AND 5 PM WEEKDAYS

Name	Title
Email	Area Code / phone # Ext

5. NAME OF BUSINESS SERVICING ENTITY LISTED IN #2 ABOVE (only applicable for nursing home/other institution contingency stock)

Name as listed on its TDDD license	TDDD License #

6. APPLICANT INTENDS DOING BUSINESS AS (Check ONE)

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

6a. NAME OF OWNER(S); OR, IF INCORPORATED, NAME AND TITLE OF OFFICERS ☐ **(check if more than two, and attach separate sheet)**

Name	Title	DOB or SSN
Name	Title	DOB or SSN

6b. NAME OF GOVERNMENT AGENCY (if applicable)

6c. TYPE OF CORPORATION, IF INCORPORATED → COPY OF CORPORATION &/OR LIMITED LIABILITY PAPERS MUST ACCOMPANY THIS APPLICATION ←

☐ General (ORC Ch 1701)	☐Non-Profit (ORC Ch 1702)	☐Limited Liability (ORC Ch 1705)	☐Medical Car (ORC Ch 1737)	☐Health Care (ORC Ch 1738)	☐Dental Care (ORC Ch 1740)	☐Professional Assoc. (ORC Ch 1785)

State Where Incorporated	**Charter #** ____________	**Charter # & copy of corporation papers must be listed/attached or application will not be processed** If ownership change, has charter # changed? Yes No Did tax ID change? Yes No

7. TRADE, CORPORATE, OR PARTNERSHIP NAME AND ADDRESS

Name	Previous Trade, Corporate, Or Partnership Name(s) & Address(es) ☐ *(If any, check box and attach separate sheet to this application)*
Mailing Address, City, State, Zip Code	Area Code / Telephone # Ext

8. LIST OTHER TDDD/WDDD LICENSES, ISSUED BY THE OHIO STATE BOARD OF PHARMACY, WHICH YOU POSSESS

Give ID #(s) only

9. CATEGORY OF LICENSE (Check only ONE)

Application is hereby made for a license as a TERMINAL DISTRIBUTOR of Dangerous Drugs, as provided in Sections 4729.54, 4729.541, 4729.55, 4729.551 and 4729.552 of the Ohio Revised Code, as follows:

☐ Category I ☐ Limited Category I ☐ Category II ☐ Limited Category II ☐ Category III ☐ Limited Category III

Drug Enforcement Administration (DEA) License # (for Category III)

-- FOR STATE BOARD OF PHARMACY USE ONLY --

Control #	Amt Rec'd	Audit #	Class	BT	Drug Category I II III L	TDDD License #
DE	LR	VC/DE QA	OK	Addendum	DONE N/A	New # / Same #

10. TYPE OF ESTABLISHMENT BEING LICENSED [Must also attach a narrative describing the specific type of business activities that will be conducted]

PHARMACIES
- ☐ Charitable pharmacy
- ☐ Clinic pharmacy
- ☐ Compounding pharmacy
- ☐ Consulting/remote order entry
- ☐ DME pharmacy
- ☐ Fluid Therapy/Infusion pharmacy
- ☐ Hospital pharmacy
- ☐ Mail Order pharmacy
- ☐ Nuclear pharmacy
- ☐ Out of State (Non-Territorial) pharmacy
- ☐ Pharmacy Serving Other Institutions
- ☐ Retail pharmacy–chain
- ☐ Retail pharmacy–independent
- ☐ Specialty pharmacy

PRESCRIBER PRACTICES
- ☐ Ambulatory Surgery Center
- ☐ Clinic
- ☐ Convenience Care Clinic (APN)
- ☐ Mobile Clinic
- ☐ Pain Management Clinic
- ☐ Practitioner Corporation - health system owned
- ☐ Practitioner Corporation – not associated with health care system
- ☐ Private Practitioner
- ☐ Urgent Care
- ☐ Veterinary Facility

- ☐ Animal Euthanasia
- ☐ Contingency Stock Location of RSOX Provider
- ☐ Dog Trainer
- ☐ Dog Warden
- ☐ EMS - Headquarters
- ☐ EMS - Satellite
- ☐ First Aid/Dispensary/ Occupational Health
- ☐ Food Processing – Use of Nitrous Oxide
- ☐ Home Health Care
- ☐ Laboratory/Research
- ☐ Manufacturing Process Use
- ☐ Physical Therapy Facility
- ☐ Retail Seller of Medical Oxygen (RSOX)

- ☐ Animal Shelter / Zoo
- ☐ Contingency Stock in Correctional Institution
- ☐ Contingency Stock in LTC Facility
- ☐ Correctional Institution
- ☐ Disposal/Incineration Facility
- ☐ Hospice - Inpatient
- ☐ Hospice - Outpatient
- ☐ Sports Training Facility
- ☐ Teaching Institution
- ☐ OTHER (describe) ______________________ ______________________

11. RECORD OF ADJUDICATIONS AND FINES IMPOSED

Has the applicant, owner(s), Responsible Person, any agent or any employee of the location being licensed, or any officer of the corporation, ever been the subject of disciplinary action by any state or federal agency; even if subsequently dismissed or resolved without formal discipline?

☐ NO ☐ YES If yes, give reason and detailed explanation on separate sheet - also include a copy of the discipline document with the application.

12. RECORD OF CHARGES, CONVICTIONS, AND FINES IMPOSED

Does the applicant, owner(s), Responsible Person, any agent or any employee of the location being licensed, or any officer of the corporation, have a record of arrest or charges pending or have a conviction of a felony or a misdemeanor other than a minor traffic violation (even if expunged, dismissed or sealed)?

☐ NO ☐ YES If yes, explain in detail on separate sheet listing names and addresses of the court or government agency and dates such charges were filed. Send a certified copy of the charging instrument and the final judgment entry for each occurrence.

NOTE: Pursuant to Section 2953.33(B) of the Ohio Revised Code, you must answer in the affirmative if you have a record of a charge or conviction that has subsequently been sealed or expunged.

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

Print Name	Title	Area Code / Telephone # Ext
Email		

I DECLARE UNDER PENALTIES OF SECTION 2921.13 OF THE OHIO REVISED CODE THAT THIS APPLICATION HAS BEEN EXAMINED BY ME AND, TO THE BEST OF MY KNOWLEDGE AND BELIEF, IS A TRUE, CORRECT, AND COMPLETE APPLICATION.

SIGNATURE of APPLICANT	***DATE Signed***	***DOB or SSN***

14. STATEMENT OF INDIVIDUAL RESPONSIBLE FOR SUPERVISION AND CONTROL OF DANGEROUS DRUGS

I HEREBY AGREE to and do submit to the jurisdiction of the Ohio State Board of Pharmacy and to the laws and rules of Ohio for the purposes of the enforcement of Chapters 2925., 3715., 3719., and 4729. of the Ohio Revised Code, and Chapter 4729 of the Ohio Administrative Code; and, I 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), O.R.C.

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 Ohio State Board of Pharmacy. I also understand that if and when this business is discontinued that a "Written Notice of Discontinuing Business" form must be secured from the Ohio State Board of Pharmacy, completed by me, and returned to their offices with the license being discontinued as required in Rule 4729-9-07 of the Ohio Administrative Code.

I DECLARE UNDER PENALTIES OF SECTION 2921.13 OF THE OHIO REVISED CODE THAT THIS APPLICATION HAS BEEN EXAMINED BY ME AND, TO THE BEST OF MY KNOWLEDGE AND BELIEF, IS A TRUE, CORRECT, AND COMPLETE APPLICATION.

SIGNATURE of Responsible Person	***DATE Signed***	PRINT OR TYPE NAME
Area Code / Telephone # Ext	Email	

QUALIFICATIONS

☐ **RPh** License # ______________________ ☐ **MD** License # ______________________ ☐ **DO** License #

☐ **DVM** License # ______________________ ☐ **DDS** License # ______________________ ☐ **DPM** License #

☐ **APN** CTP License # ______________________ Note: Must also submit signed APN statement

☐ **PhD/Chemist** - Laboratories Only Title ______________________ SSN ______________________

☐ **Other** ______________________ Title ______________________ Professional Lic # or SSN ______________________

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E.M.S. APPLICATION REQUIREMENTS

This checklist will assist you in submitting a correct and complete application for a Terminal Distributor of Dangerous Drugs (TDDD) license. The complete application includes all supporting documents listed below. Refer to ORC 4729.54(C) & (D). Incomplete applications will delay the licensing process.

ALL ITEMS BELOW MUST BE SUBMITTED BEFORE PROCESSING CAN BEGIN

☐ Completed application: FORM #0600 with original signatures

☐ CHECK/MONEY ORDER for appropriate category (Limited I, II, or III)

☐ LIST OF PERSONNEL – Use form included or spreadsheet with same info

(1) Basic EMT-Bs, Intermediate EMT-Is, and Paramedics EMT-Ps
(2) List MUST include:
  (a) Name
  (b) Certification #
  (c) Level of certification (EMT-B, EMT-I, EMT-P)
  (d) Expiration date of that certification

☐ PROTOCOL/STANDING ORDERS, which must be signed and notarized

(1) Submit copy of the protocol on a CD. Label the CD with your E.M.S. name, E.M.S. TDDD license # (or location if this is a new application & no # yet), and the date the protocol is effective.
(2) Submit cover letter stating that the Medical Director has reviewed and approved accompanying protocol. This letter must be signed by the Medical Director and notarized.
NOTE: Only dangerous drugs listed on the Drug Addendum may be purchased and stored at this location. Over-the-Counter medications are not required to be listed on the Drug Addendum but must be included in the notarized protocols.

For drugs to be used in a true EMERGENCY, a protocol is a definitive set of treatment guidelines that include definitive orders for drugs and their specified dosages. The protocol must specifically define the intended audience, list the drug name and strength, and give specific instructions on how to administer the drug. [OAC 4729-5-01(L)]

Special situation drugs (i.e.,WMD prophylaxis, vaccines) may be requested by the Medical Director by including the following signed, notarized statement above the list of these particular requested drug(s):

> “The drugs listed below will only be used when I give a direct order to an authorized health care professional to administer such drugs in specific situations."

☐ DRUG LIST

(1) This list is a compilation of all drugs approved for use in the protocol
(2) Addendum is generated from this list
(3) It must contain for each drug: (a)
the brand name (if applicable) (b)
the generic name
(c) strength to be stocked (not the dosage that will be given/protocol)
(d) dosage form
(e) National Drug Code (NDC) #
The NDC # is the identifying code given to a drug product by the Food and Drug Administration (FDA) when that agency approves the drug. It is usually on the drug container, but can also be obtained on the FDA website or from a hospital or retail pharmacy.
(4) the drug list must be signed by your medical director and notarized

NOTE: There is no fee to change the drug list/addendum. So please send your additions/deletions to the Board whenever your protocol/drug list changes so that it stays current.

☐ SATELLITE LOCATION(S)

(1) Each and every location that will store drugs must be licensed.
(2) One fee covers the headquarters and its satellite location(s).
(3) Must list each location with initial application. Thereafter, a new application and fee will be required when the information in the previous license application changes. The exception is during renewal when additions can be made using instructions accompanying the renewal application.
(4) For each satellite location, submit:
(a) Name
(b) Address
(c) Limited Category of drugs needed (I, II, or III)
(d) Indicate if same protocol & drug list as Headquarters is used
(e) List of personnel

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E.M.S. INFORMATION SHEET FOR NEW OR CHANGE LICENSES

Complete this form & return with application, other required documents, and fee.

TYPE OR PRINT LEGIBLY

NAME OF E.M.S.____ LIMITED CATEGORY________

E.M.S. DEA # (if applicable) ______________________________

MEDICAL ADVISOR (Ohio licensed physician who approves protocol and performs other advisor related activities)

Name		Title
Street Address, City, State, Zip Code (No P.O. Box)		Area Code / Phone # Ext
Ohio Medical License #	Email	

RESPONSIBLE PERSON (Individual who signs drug license – must be an Ohio licensed physician or pharmacist)

Name		Title
Street Address, City, State, Zip Code (No P.O. Box)		Area Code / Phone # Ext
Ohio Professional License #	Email	

CONTACT PERSON

Name		Title
Area Code/Phone # Ext	Email	

E.M.S. GENERAL INFORMATION

Business Office Area Code/Phone # Ext	Dispatcher Area Code/Phone # Ext

TYPE OF E.M.S. (Check all that apply)

☐ City	☐ Commercial Service	☐ Law Enforcement
☐ County	☐ Funeral Home	☐ Professional Fire
☐ Township	☐ Hospital	☐ Volunteer Fire
☐ State	☐ Industrial	☐ Private Ambulance Service
☐ First Responder	☐ Joint Ambulance District	☐ Transport Only
☐ Other		

DRUG SUPPLY

Source of Protocol	Date Protocol Last Submitted

Are drugs replaced through ☐ Exchange Box and/or ☐ Individual Units

List name and addresses of sources with whom drugs are exchanged or purchased (i.e., hospital, wholesaler, retail pharmacy, etc.) Use back of this page if more than 3 sources.

1. ______________________________
2. ______________________________
3. ______________________________

OHIO STATE BOARD OF PHARMACY
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Columbus, OH 43215-6126
Phone: 614-466-4143 Fax: 614-752-4836
Website: www.pharmacy.ohio.gov
E-mail: licensing@bop.ohio.gov

License # 02 ______________________
License Name

____

Date: ______________________

LIMITED LICENSE PERSONNEL LIST - RENEWAL

List the name, professional license #, type of professional license or certification level (if applicable), and expiration date of the license or certification. You may submit your own list (i.e., Excel spreadsheet) as long as it contains all of the required information.

(Ex. Type of license/Certification Level - RN, MD, EMT-B, EMT-P)

NAME	PROFESSIONAL LIC #	TYPE OF LICENSE/ CERTIFICATION LEVEL	EXPIRATION DATE
Ex. - John A. Smith	RN123456	RN	8/31/25

(Duplicate this form as necessary)