

**OFFICE OF PHARMACY AFFAIRS (OPA)  
HOSPITAL CERTIFICATION OF OWNERSHIP/OPERATION  
BY A UNIT OF STATE/LOCAL GOVERNMENT**

**In order to meet the eligibility requirement (Section 340B(a)(4)(L)(i)) of ownership/operation by a unit of state/local government this certification must be completed and signed by a representative from both parties specified below.**

\_\_\_\_\_  
Name of Hospital

\_\_\_\_\_  
Street Address, City, State, Zip

**I certify that the aforementioned hospital organization is owned and/or operated by a unit of the State or local government.** (Please check the appropriate box below)

**Owned**

**Operated**

**Both**

\_\_\_\_\_  
Signature of State or Local Government Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of State or Local Government Official (*please print or type*)

\_\_\_\_\_  
Title and Unit of Government

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Ext.

\_\_\_\_\_  
E-Mail Address

**The undersigned represents and confirms that he/she is fully authorized to legally bind the covered entity and certifies that the contents of any statement made or reflected in this document are truthful and accurate. I certify that the ownership and/or operating status identified above is currently valid, and agree to inform the Office of Pharmacy Affairs of any material change as soon as reasonably possible.**

\_\_\_\_\_  
Signature of Hospital Authorizing Official

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name & Title of Hospital Authorizing Official (e.g.: CEO, CFO, COO) (*Please print or type*)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Ext.

\_\_\_\_\_  
E-Mail Address

This registration form must be completed and submitted according to the established deadlines that are published on the OPA website ([www.hrsa.gov/opa](http://www.hrsa.gov/opa)).

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-XXXX. Public burden is estimated to average XX minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-33, Rockville, Maryland 20857