

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

**This certification must be completed and signed by representatives from the parties specified below acknowledging the eligibility requirement in section 340B(a)(4)(L)(i) of the Public Health Service Act regarding ownership/operation by a unit of state/local government.**

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Name of Hospital

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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**

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State or Local Government Official Signature

Date

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

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Title and Unit of Government

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Phone Number

Ext.

E-Mail Address

**The undersigned certifies 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. The undersigned certifies that the ownership and/or operating status identified above is currently valid, and agrees to inform the Office of Pharmacy Affairs of any change as soon as possible.**

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Hospital Authorizing Official Signature

Date

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 0915-0327. Public reporting burden for this collection of information is estimated to average 0.25 hours per response, including the time for reviewing instructions, searching existing data sources, 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 10C-031, Rockville, Maryland, 20857.

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

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Phone Number

Ext.

E-Mail Address

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