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.

_____

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** ☐

_____

State or Local Government Official Signature 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 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.

_____

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).

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).