

COVID-19 WAIVER REQUEST

1. Pharmacy/Facility Requesting Waiver

Pharmacy/Facility Name: _____

Address: _____

City, State, Zip: _____

Oklahoma License #: _____

2. Pharmacy/Facility Point of Contact Regarding Waiver Request

Name: _____

Title/Position: _____

Email Address: _____

Preferred Contact Phone #: _____

3. Reason For/Circumstances Surrounding Waiver Request:

BY SUBMITTING THIS FORM, YOU ACKNOWLEDGE UNDERSTANDING THAT:

- Submission of waiver is not a guarantee of approval; The Executive Director/Deputy Director will review requests on a case by case basis. Once processed, a written response will be sent to the email address provided above.
 - Approved waivers are not in effect until you have received such approval in writing;
- The Executive Director/Deputy Director may require further information/documentation in order to review/approve this request;
 - Requestor will be responsible to notify OSBP when waiver request is no longer needed;
 - If this request is approved, the waiver is only valid until the requestor or OSBP Executive Director/Deputy Director deems it unnecessary.

FOR OSBP OFFICE USE ONLY:

Approved

Denied

Date Waiver Granted: _____

OSBP Executive Director/Deputy Director Signature: _____