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: _____ Date Waiver Ends_____

OSBP Executive Director/Deputy Director Signature: _____