Request for Peer Review Access

The completed form must be submitted to the Board by email (support@pharmacy.ohio.gov) OR by fax (614-644-8556).

Part 1 – Peer Review Committee Information

Name of Hospital

Part 2 – Peer Review Designated Representative Information – *Designated representatives must have current OARRS accounts. There may up to three designated representatives per peer review committee.*

Designated Representative #1

First Name	Last Name
Professional License Type (MD/DO, APRN, RPH.)	Ohio License Number
Email Address Associated with OARRS Account	Date of Birth (MM/DD/YYYY)

Designated Representative #2

First Name	Last Name
Professional License Type (MD/DO, APRN, RPH.)	Ohio License Number
Email Address Associated with OARRS Account	Date of Birth (MM/DD/YYYY)

Designated Representative #3

First Name	Last Name
Professional License Type (MD/DO, APRN, RPH.)	Ohio License Number
Email Address Associated with OARRS Account	Date of Birth (MM/DD/YYYY)

Part 3 – Attestation by Designated Representative - *To be completed by the designated representative(s). Must be manually signed in ink.*

I HEREBY AGREE TO THE FOLLOWING TERMS AS A CONDITION OF USING THE OHIO AUTOMATED RX REPORTING SYSTEM (OARRS) AS A DESIGNATED REPRESENTATIVE OF A PEER REVIEW COMMITTEE:

- I WILL ONLY REQUEST INFORMATION IN OARRS, AS AUTHORIZED IN RULE 4729:8-4-01 OF THE OHIO ADMINISTRATIVE CODE, RELATING TO A PRESCRIBER WHO IS SUBJECT TO THE COMMITTEE'S EVALUATION, SUPERVISION, OR DISCIPLINE.
- THE INFORMATION IN OARRS IS PROTECTED HEALTH INFORMATION AND IS NOT A PUBLIC RECORD. I WILL NOT DISCUSS INFORMATION OBTAINED FROM THE SYSTEM WITH ANYONE OUTSIDE OF THE PEER REVIEW COMMITTEE.
- I MAY AUTHORIZE AS MY DELEGATE ONE PERSON REQUESTING INFORMATION IN OARRS FOR THE PURPOSE OF REVIEW BY THE PEER REVIEW COMMITTEE ONLY IF I DIRECTLY SUPERVISE THAT PERSON. MY DELEGATE MUST HAVE THEIR OWN, INDIVIDUAL EMPLOYEE ACCOUNT REGISTERED WITH OARRS. I MUST APPROVE, AUTHORIZE, AND AM RESPONSIBLE FOR THE DELEGATE'S REQUESTS FOR INFORMATION.
- I UNDERSTAND THAT ANY VIOLATION OF OARRS DATA – EITHER IMPROPERLY ACCESSING OR IMPROPERLY DISSEMINATING OR OTHERWISE – MAY SUBJECT ME TO CRIMINAL AND/OR ADMINISTRATIVE PENALTIES, AS SET FORTH IN OHIO LAW.

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE ANSWERS PROVIDED ON THIS FORM ARE **TRUE, CORRECT, AND COMPLETE.**

Signature of Designated Representative #1	Date Signed
Print Name	
Signature of Designated Representative #2	Date Signed
Print Name	
Signature of Designated Representative #3	Date Signed
Print Name	

Part 4 – Attestation by Physician Responsible for Operation of Peer Review Committee - *To be completed by an Ohio licensed physician who is responsible for the operation of the hospital peer review committee. Must be manually signed in ink. NOTE: This physician may also be listed as a designated representative in Part 2 of this form.*

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE PERSONS LISTED IN THIS FORM ARE THE DESIGNATED REPRESENTATIVES OF THE HOSPITAL'S PEER REVIEW COMMITTEE FOR THE PURPOSES OF ACCESSING OARRS IN ACCORDANCE WITH SECTION 4729.80 OF THE OHIO REVISED CODE.	
Signature of Responsible Physician	Date Signed
Print Name	