

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

**In order to meet the eligibility requirement (Section 340B(a)(4)(L)(i)) of ownership/operation by a unit of state/local government this certification must be completed and signed by a representative from both parties specified below.**

\_\_\_\_\_  
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**

\_\_\_\_\_  
Signature of State or Local Government Official

\_\_\_\_\_  
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 represents and confirms 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. I certify that the ownership and/or operating status identified above is currently valid, and agree to inform the Office of Pharmacy Affairs of any material change as soon as reasonably possible.**

\_\_\_\_\_  
Signature of Hospital Authorizing Official

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Ext.

\_\_\_\_\_  
E-Mail Address