Please check one of the below options. ***By completing this form I certify that*:**

_____ I am licensed as a TDDD. My TDDD license number is: _____
My TDDD license expires: _____.

_____ A list of all Ohio locations where I receive and store drugs for use in my practice is attached (if multiple locations).

OR

_____ I am exempt from TDDD licensure because I am doing business as a **sole proprietor (not incorporated in any way)** and am authorized to use drugs in my practice.

_____ I am exempt from TDDD licensure because I am doing business as a **sole shareholder** of a corporation, a limited liability company, or a professional association and am authorized to use drugs in my practice.

_____ A list of all Ohio locations where I receive and store drugs for use in my practice is attached (if multiple locations).

*MAH Account #_____

*Account Name_____

Billing Address_____

*Shipping Address_____

Phone Number_____ Email address_____

*TDDD Responsible Person Name_____

OH Vet License_____ Exp. Date_____

*Signature_____ *Date_____

*Denotes required fields

Return this form via FAX to 908-259-3951 or via email to: Pricingusaah@merck.com