



Application Form:

Please provide the most up-to-date contact information for all individuals where information is requested and include this form along with the business plan when submitting to OPA.

Team Name _____

Team Captain

Name: _____

Pharmacy School: _____

Mailing Address: _____

Email Address: _____

Additional Team Members (up to three):

1. _____

Email: _____

2. _____

Email: _____

3. _____

Email: _____

Team Advisor

Name: _____ **Phone:** _____

Employer: _____

Mailing Address: _____

Email Address: _____

Please mail 6 copies of the business plan to:

**IPBPC c/o Kathy Nameth
Ohio Pharmacists Association
2674 Federated Blvd.
Columbus, OH 43235**