Innovative Pharmacy Business Plan Competition Application

Please provide current contact information for all individuals where requested and include this form along with the business plan when submitting to OPA.

Team Name: ____

Team Captain Name: ____

Pharmacy School: ____

Email Address: ______________________________________

Additional Team Members (up to three):

1. ____

   Email Address: ____

2. ____

   Email Address: ____

3. ____

   Email Address: ____

Team Advisor Information

Name: ________________________________ **Phone:** ________________

Employer: ____

Mailing Address: ____

Email Address: ____

Please email your business plan, timestamped by February 1, 2025, to jfranklinkearns@ohiopharmacists.org.