Application

for

Pharmacist Collaborative Practice Certification

Board *of* Pharmacy
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://floridaspharmacy.gov/
Email: info@floridaspharmacy.gov
Phone: (850) 245-4474
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DH5059-MQA, 08/2020, Rule 64B16-31.001, F.A.C.

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P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 921-5389
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All applicants must hold a current Florida Pharmacist license that is active and in good standing.

Pharmacist Collaborative Practice Certification

Prior to providing services under a collaborative pharmacy practice agreement, a pharmacist must be certified by the board. Additionally, a pharmacist must enter into a written agreement with a physician licensed under Chapter 458 or Chapter 459, Florida Statutes, in which a collaborating physician authorizes a pharmacist to provide specified patient care services for chronic health conditions. Please refer to section 465.1865, Florida Statutes, prior to submitting your application.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (This address is where mail and your certification will be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box – this address will be posted on the Department of Health's website)

_____ _____ _____
Street Apt. No. City

_____ _____ _____ _____
State ZIP Country Business Telephone (Input without dashes)

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

Name: _____

2. LICENSURE HISTORY

A. What is your Florida Pharmacist (PS) license number? _____

3. CERTIFICATION TRAINING

To qualify for certification, an applicant must have completed an initial 20-hour certification course that meets the statutory and rule requirements of section 465.1865, Florida Statutes, and Rule 64B16-31.003, F.A.C.

B. Have you successfully completed an initial 20-hour course approved by the Florida Board of Pharmacy? ☐ Yes ☐ No

If yes, provide a copy of the certificate of completion and the following information.

Provider Name	Provider Number	Date of Completion	Certificate Number

4. APPLICANT BACKGROUND

To qualify for certification, an applicant must have earned a degree of doctor of pharmacy or have completed 5 years of experience as a licensed pharmacist.

A. Have you earned a degree of doctor of pharmacy? ☐ Yes ☐ No

If yes, please list the name of university, college, or school of pharmacy you attended.

School Name	City/State or Country	Graduation Date	Degree Awarded

B. Have you completed 5 years of experience as a licensed pharmacist? ☐ Yes ☐ No

If yes, please list your experience below.

Employer	Location Address	Dates (From-To) MM/DD/YYYY

Name: _____

5. PROFESSIONAL LIABILITY INSURANCE

To provide services under a collaborative pharmacy practice agreement, a pharmacist must maintain at least $250,000 of professional liability insurance coverage. A pharmacist who maintains professional liability insurance coverage as a requirement of the Test and Treat Certification, pursuant to section 465.1895, Florida Statutes, satisfies this requirement.

A. Do you maintain at least $250,000 of professional liability insurance? ☐ Yes ☐ No

If "Yes," provide the following information:

Insurance Provider Name	Policy Number	Policy Expiration Date

6. SYSTEM TO MAINTAIN RECORDS

To provide services under a collaborative pharmacy practice agreement, a pharmacist must have established a system to maintain records of all patients receiving services under a collaborative pharmacy practice agreement for a period of 5 years from each patient's most recent provision of services, pursuant to section 465.1865, Florida Statutes.

A. Have you established a system to maintain records of all patients receiving services under a collaborative pharmacy practice agreement? ☐ Yes ☐ No

7. COLLABORATING PHYSICIAN

If available, provide the following information for the physician licensed under chapter 458 or 459, Florida Statutes, with whom you have entered into an agreement.

Physician Name: _____

Physician License #: _____

COLLABORATIVE PHARMACY PRACTICE AGREEMENT INFORMATION

Section 465.1865(3), Florida Statutes, requires each collaborative pharmacy practice agreement include terms and conditions that are appropriate to the pharmacist's training and the services delegated to the pharmacist must be within the collaborating physician's scope of practice.

The collaborative practice agreement must include the following information:

1. Name of the collaborating physician's patient or patients for whom a pharmacist may provide services.
2. Each chronic health condition to be collaboratively managed.
3. Specific medicinal drug or drugs to be managed by the pharmacist for each patient.
4. Circumstances under which the pharmacist may order or perform and evaluate laboratory or clinical tests.
5. Conditions and events upon which the pharmacist must notify the collaborating physician and the manner and timeframe in which such notification must occur.
6. Beginning and ending dates for the collaborative pharmacy practice agreement and termination procedures, including procedures for patient notification and medical records transfers.
7. A statement that the collaborative pharmacy practice agreement may be terminated, in writing, by either party at any time.

The collaborative pharmacy practice agreement shall automatically terminate 2 years after execution if not renewed. The pharmacist, along with the collaborating physician, must maintain on file the collaborative pharmacy practice agreement at his or her practice location, and must make such agreements available to the department or board upon request or inspection.

A pharmacist who enters into a collaborative pharmacy practice agreement must submit a copy of the signed agreement to the board before the agreement may be implemented.

8. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Pursuant to Title 42 United States Code § 666(a)(13), the department is required and authorized to collect Social Security numbers relating to applications for professional licensure. Additionally, section (s.) 456.013(1)(a), Florida Statutes (F.S.), authorizes the collection of Social Security numbers as part of the general licensing provisions.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Social Security Information- * Under the Federal Privacy Act, disclosure of Social Security numbers is voluntary unless specifically required by federal statute. In this instance, Social Security numbers are mandatory pursuant to Title 42 United States Code § 653 and 654; and s. 456.013(1), 409.2577, and 409.2598, F.S. Social Security numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to ensure compliance with child support obligations. Social Security numbers must also be recorded on all professional and occupational license applications and will be used for license identification pursuant to Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act. 104 Pub. L. Section 317). Clarification of the SSA process may be reviewed at www.ssa.gov or by calling 1-800-772-1213.

Name: _____

9. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for certification in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067 and 775.083, Florida Statutes.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print out this application and sign it or sign it digitally. MM/DD/YYYY

Documentation must be sent to the board office at info@floridaspharmacy.gov, or mailed to:

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258