Application

for

Pharmacist Test and Treat Certification

Board *of* Pharmacy
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://floridaspharmacy.gov/
Email: info@floridaspharmacy.gov
Phone: (850) 245-4474
Fax: (850) 921-5389

DH5060-MQA, 08/2020, Rule 64B16-31.033, F.A.C.

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P.O. Box 6330
Tallahassee, FL 32314-6330
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All applicants must hold a current Florida Pharmacist license that is active and in good standing.

Pharmacist Test and Treat Certification

Prior to testing or screening for and treating minor, nonchronic health conditions under a written protocol, a pharmacist must be certified by the board. Additionally, a pharmacist must practice within the framework of a written protocol with a supervising physician licensed under Chapter 458, Florida Statutes, or Chapter 459, Florida Statutes. Please refer to Section 465.1895, 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 should 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 465.1895, Florida Statutes, and Rule 64B31.035, F.A.C.

A. 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. PROFESSIONAL LIABILITY INSURANCE

To test or screen for and treat minor, nonchronic health conditions within the framework of a written protocol, a pharmacist must maintain at least $250,000 of professional liability insurance coverage. A pharmacist who maintains professionals liability coverage as a requirement of their Collaborative Practice Certification 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

5. REPORTING REQUIREMENTS

To test or screen for and treat minor, nonchronic health conditions within the framework of a written protocol, a pharmacist must report a diagnosis or suspected existence of a disease of public health significance to the Department of Health pursuant to section 381.0031, Florida Statutes.

A. Have you reviewed the Disease Reporting and Management Information at http://www.floridahealth.gov/diseases-and-conditions/index.html? ☐ Yes ☐ No

6. SYSTEM TO MAINTAIN RECORDS

To test or screen for and treat minor, nonchronic health conditions within the framework of a written protocol, a pharmacist must furnish patient records to a health care practitioner designated by the patient upon request. Additionally, a pharmacist must maintain records of all patients receiving services for a period of five (5) years from each patient's most recent provision of service.

A. Have you established a system to maintain records of all patients receiving services within the framework of a written protocol? ☐ Yes ☐ No

Name: _____

7. SUPERVISING PHYSICIAN

If available, provide the following information for the physician licensed under chapter 458 or 459, Florida Statutes (F.S.), with whom you have entered into a protocol.

Physician Name: _____

Physician License #**:** _____

8. WRITTEN PROTOCOL INFORMATION

Each written protocol must include particular terms and conditions imposed by the supervising physician relating to the testing and screening for and treatment of minor, nonchronic health conditions. The terms and conditions must be appropriate to the pharmacist's training.

The written protocol must include, at a minimum, the following information:

1. Specific categories of patients who the pharmacist is authorized to test or screen for and treat minor, nonchronic health conditions.
2. The physician's instructions for obtaining relevant patient medical history for the purpose of identifying disqualifying health conditions, adverse reactions, and contraindications to the approved course of treatment.
3. The physician's instructions for the treatment of minor, nonchronic health conditions based on the patient's age, symptoms, and test results, including negative results.
4. A process and schedule for the physician to review the pharmacist's actions under the protocol.
5. A process and schedule for the pharmacist to notify the physician of the patient's condition, tests administered, test results, and course of treatment.

A pharmacist who enters into a written protocol must submit a copy of the protocol to the board.

9. 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: _____

10. 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, F.S.

I am aware that my certification may be suspended or revoked if I violate any pharmacy law, rule or regulation, or the Florida Board of Pharmacy Code of Conduct.

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), F.S., 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