

Mailing Address: PO Box 2649
Harrisburg, PA 17105-2649

Courier Address: 2601 N. Third Street
Harrisburg, PA 17110

APPLICATION FOR AUTHORIZATION TO ADMINISTER INJECTABLE MEDICATIONS, BIOLOGICALS AND IMMUNIZATIONS (#854 111, Rev. 8/15)

Please note that this application is for use only by individuals who have applied for a Pennsylvania pharmacist license or currently hold an active Pennsylvania pharmacist license. The Pennsylvania State Board of Pharmacy (Board) must first promulgate new regulations to implement the amendments to the Pharmacy Act Section 9.2(b) before pharmacy interns are permitted to apply for the authorization to administer injectable medications, biologicals and immunizations. The Board will post information on its web site once these regulations are promulgated.

Instructions:

1. **The pharmacist should fully complete page one of the application and attach the proper fee.** Since licenses are not forwarded, be sure to provide a valid mailing address. If necessary, file an address change form for your pharmacist license.
2. **Attach a photocopy of your current CPR card, including the front, back and any necessary legend, or your CPR certificate.** Note: Pharmacists who hold an active authorization to administer injectable medications, biologicals and immunizations must maintain at all times a current basic cardiopulmonary resuscitation (CPR) certificate issued by the American Heart Association, American Red Cross or a similar health authority or professional body approved by the Board. A list of approved CPR providers/programs is posted at www.dos.pa.gov/pharm.
3. **Complete the top of application page two** and make arrangements to have the education/training provider complete the "Certification of Education and Training" section of page two. Please note that the **education/training provider must directly submit** page two to the Board office.
4. Keep in mind that your education/training program is valid for only two years. You must **apply for and be issued** the authorization within two years of completing the education/training program or you will be required to complete an entirely new education/training program.
5. While you hold an active authorization to administer injectable medications, biologicals and immunizations, you must maintain professional liability insurance coverage in the amount of at least \$1,000,000 per occurrence or claims made in accordance with Section 9.2(a)(6) of the Pharmacy Act. Failure to maintain insurance coverage as required will subject you to disciplinary proceedings. You must provide proof of insurance coverage to the Board upon request of authorized representatives of the Board.
6. If the Board is in a pharmacist license renewal period (normally July through September of even-numbered years) and your authorization to administer injectables application is pending, your pharmacist license must be renewed before your authorization to administer injectables can be issued.
7. If your original application is more than a year old and the authorization has not been issued to you, you must submit an entirely new application and the application fee.

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Attach a \$30.00 check or money order made payable to the "Commonwealth of PA." Fees are not refundable nor transferable. Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. If your original application is more than a year old and the authorization has not been issued to you, you must submit an entirely new application and the application fee.

Name: _____, _____, _____
Last First Middle

Home address: _____

E-mail address: _____

Pharmacist license number*: _____ Exp. date of pharmacist license: _____

*If your pharmacist license is pending, please provide your social security no.: _____

STATEMENT

I verify that while I hold an active authorization to administer injectable medications, biologicals and immunizations I will maintain professional liability insurance coverage in the amount of at least \$1,000,000 per occurrence or claims made in accordance with Section 9.2(a)(6) of the Pharmacy Act. I understand that failure to maintain insurance coverage as required will subject me to disciplinary proceedings. I will provide proof of insurance coverage to the Pennsylvania State Board of Pharmacy (Board) upon request of authorized representatives of the Board.

I verify that I hold and will maintain a current basic cardiopulmonary resuscitation (CPR) certificate issued by the American Heart Association, American Red Cross or a similar health authority or professional body approved by the Board. **A photocopy of my current CPR card (front, back and any necessary legend) or CPR certificate is attached.**

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Pharmacist Signature

Date

Instructions to the Pharmacist:

1. Please provide your name and pharmacist license number here.

Name: _____

Pharmacist license number*: _____

*If your license is pending, please provide your social security no.: _____

2. Submit this page to your education/training provider for completion. **Your education/training provider** must **directly** mail the completed certification to the Board of Pharmacy at PO Box 2649, Harrisburg, PA 17105-2649. If using a courier service, the **courier** address is 2601 N. Third Street, Harrisburg, PA 17110.

CERTIFICATION OF EDUCATION AND TRAINING

As the authorized representative of _____,
Name of Education and Training Provider

I verify that this program provider/educational institution is accredited by the Accreditation Council for Pharmacy Education and that the above-noted individual has satisfactorily completed an academic and practical curriculum related to the administration of injectable medications, biologicals, and immunizations that meets the requirements under Board Regulation Section 27.407.

The course was completed by the above-noted individual on _____.
Date

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Signature of Representative Date

Printed Name of Representative

Place official
organizational seal
or stamp here.

Street Address of Education/Training Provider

City, State and Zip Code of Education/Training Provider

****IMPORTANT INFORMATION FOR THE EDUCATION/TRAINING PROVIDER****

The Board of Pharmacy requires direct source verification of education. All documents must be submitted by the education/training provider in an envelope containing the **preprinted return address of the provider**. If a provider is unable to meet this requirement, each educational document must be notarized prior to submission.