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**AUTHORIZATION TO ADMINISTER INJECTABLE MEDICATIONS,
BIOLOGICALS AND IMMUNIZATIONS -
CERTIFICATION OF PROFESSIONAL LIABILITY INSURANCE**

(#854 142, Rev. 12/15)

This form is to be completed by pharmacists who are applying for the authorization to administer injectables if one of the following statements apply:

- 1. The pharmacist's original application for the authorization to administer injectable medications, biologicals and immunizations was completed prior to August 25, 2015 and/or lacks the insurance verification statement.*
- 2. The pharmacist applied online for the authorization to administer injectable medications, biologicals, and immunizations.*

I, _____, verify that while I hold an
Full Name

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 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.

Written Signature

Date

Pennsylvania Pharmacist License Number (or Social Security Number if
Pennsylvania pharmacist license is pending)