PENNSYLVANIA STATE BOARD OF PHARMACY
Mailing Address: PO Box 2649, Harrisburg PA 17105-2649
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717-783-7156
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st-pharmacy@pa.gov

CERTIFICATION OF PROFESSIONAL LIABILITY INSURANCE FOR SETTINGS OTHER THAN AN INSTITUTIONAL SETTING

(#854 124, Rev. 1/20)

This form is to be completed by pharmacists who will engage in the management of drug therapy under a collaborative agreement in a setting other than an institutional setting. The completed form must be submitted to the Board of Pharmacy office with the collaborative agreement.

I, _____, certify that I am engaging in the management of drug
Printed Name

therapy under a collaborative agreement and maintain professional liability insurance in the amount of at least $1,000,000 per occurrence or claims made in accordance with the Pharmacy Act Section 9.3(c) and Board Regulation Section 27.312.

I verify that this form 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 form 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's Written Signature

_____
Date (month/day/year)

_____
Pharmacist's License Number

List below the names ***and*** license numbers of the physicians associated with the collaborative agreement that is being submitted with this insurance form. If additional space is needed, attach the information to this form.

Physician's Printed Name	Physician's License No.
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____