DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

IMMUNIZATION ADMINISTRATION CERTIFICATION APPLICATION AND INFORMATION

December 2015

DH MQA 1125, 12/15
Rule 64B16-26.1032, F.A.C.

General Information

Requirements for Pharmacist Immunization Administration Certification:

To become certified to administer immunizations and epinephrine, a pharmacist must meet the following requirements.

1) Must hold a Florida pharmacist license that is active and in good standing.

2) Must successfully complete an immunization administration certification program of no fewer than 20 hours, approved by the Florida Board of Pharmacy.

3) Must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of immunizations by the pharmacist. The written protocol shall include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer immunizations and epinepherine. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for immunization. Supervising physicians shall review the administration of immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician.

4) Must maintain at least $200,000 of professional liability insurance.

5) Must obtain written permission from the pharmacy owner, if the applicant is to administer immunizations while acting as an employee of a pharmacy.

Requirements for Registered Pharmacy Intern Immunization Administration Certification:

To become certified to administer immunizations, a registered pharmacy intern must meet the following requirements.

1) Must hold a pharmacy intern registration that is active and in good standing.

2) Must successfully complete an immunization administration certification program of no fewer than 20 hours, approved by the Florida Board of Pharmacy.

3) Must be directly supervised by a licensed pharmacist whose license is clear and active and who is also certified to administer vaccines. The supervision must be on a ratio of one pharmacist to one intern.

Please be advised the Immunization Administration Certification will be added to your Registered Pharmacy Intern license and will not automatically transfer over to your Pharmacist license.

You will be required to submit a new Immunization Administration Certification application, fee, and all required supporting documentation in order to administer vaccines as a licensed pharmacist.

Application Processing

Please read all application instructions before completing your application.

Within 7-14 days of receipt of your application and fees, the board office will notify you of the receipt of your application, any required documents, and your status. If your application is complete, you will be issued the certification within 7-14 days. If your application is incomplete, you will be notified in writing of the missing documents required to complete your application.

APPLICATION REQUIREMENTS FOR IMMUNIZATION ADMINISTRATION CERTIFICATION

Please submit the following to the Florida Board of Pharmacy:
P.O. Box 6320, Tallahassee, FL 32314-6320

ITEM #1 – Immunization Administration Certification Application: All sections must be completed in full. Failure to submit a complete application will result in a processing delay. If you provide false information, the board *may* deny your application for certification. **Please attach a check payable to THE FLORIDA DEPARTMENT OF HEALTH in the amount of $55.00. *No fee is required for Pharmacy Interns.**

Immunization Administration Certification Program: Pharmacists and Registered Pharmacy Interns must successfully complete an immunization administration certification program of no fewer than 20 hours, approved by the Florida Board of Pharmacy Continuing Education Committee. **Please attach a copy of your certificate of completion to your application.**

Protocol: Pharmacists must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of immunizations by the pharmacist. The written protocol shall include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer immunizations. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for immunization. Supervising physicians shall review the administration of immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician.

A pharmacist may not enter into a protocol that is to be performed while acting as employee without the written approval of the owner of the pharmacy.

Professional Liability Insurance: Upon becoming certified, pharmacists must maintain at least $200,000 of professional liability insurance. **Please attach a copy of your professional liability insurance policy to your application. (NOTE: If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company letterhead verifying that you are covered under their company policy.)**

APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation to the board, will result in an incomplete application. **Final approval cannot be granted until the application is complete**. Faxed applications will not be accepted.

_____ **Immunization Administration Certification Application (Item #1)**

_____ **Immunization Certification Program –** All pharmacists must complete an immunization administration certification course prior to board certification. The course shall be no less than twenty (20) contact hours, shall be board approved, and shall cover the subjects listed in subsection 64B16- 26.1031, F.A.C. Please refer to CE Broker's website at www.CEBroker.com for a list of approved providers. **(Submit a copy of the course completion certificate to the Board of Pharmacy.)**

The remaining requirements apply to pharmacists only.

____ Check made payable to the FLORIDA DEPARTMENT OF HEALTH in the amount of $55.00. *** No fee is required for Pharmacy Interns**.

_____ **Protocol**– All pharmacists must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. . **(Submit a copy of the protocol between the applicant and practitioner.)**

_____ **Professional Liability Insurance** – All pharmacists must maintain at least $200,000 of professional liability insurance. **(Submit a copy of the professional liability insurance policy to the Board of Pharmacy. NOTE: If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company letterhead verifying that you are covered under their company policy.)**

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P.O. Box 6320 • Tallahassee, FL 32314-6320
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www.floridaspharmacy.gov

ITEM #1 – IMMUNIZATION ADMINISTRATION CERTIFICATION APPLICATION (3015)

Application Type:____Pharmacist *Fee: $55.00 (2201) ____Pharmacy Intern (2202) * No Fee Required

1. Biographical Data

Last Name	First Name	Middle Name

Mailing Address	City	State	Zip

Home Phone Number	Business Phone Number	E-Mail Address

2. Equal Opportunity Data – We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43FR38295 (August 25, 1978). The information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: 0 Male 0 Female
RACE: 0 Caucasian 0 Black 0Hispanic 0 Asian 0 Native American 0 Other

3. Do you have a Florida Pharmacist (PS) license or a Pharmacy Intern (PSI) registration active and in good standing? If yes, what is the license or registration number? **If an Intern license number is listed in this section the Immunization Certification will be added to the Intern license and will not automatically transfer to a pharmacist license.**

Yes_____ No_____ Florida License Number: PS_____**or** PSI_____

4. Have you ever held an immunization administration certification in Florida? If yes, what was the certification number?

Yes_____ No_____ Florida Certification Number: _____

5. Immunization Administration Certification Program - Have you successfully completed a Florida Board of Pharmacy approved immunization administration certification program? If yes, please provide the provider name, provider number, date of completion, and certificate number. Please attach a copy of the certificate of completion to this application.

Yes_____ No _____

Provider Name	Provider Number	Date of Completion	Certificate Number

6. Protocol Information (pharmacists only) – Please provide the name, license number, address, and contact telephone number of the physician licensed under chapter 458 or 459, *Florida Statutes*, with whom you have entered into a protocol. Please attach a copy of the protocol to this application.

Physician Name	Physician License Number	Contact Telephone Number

Mailing Address

City	State	Zip Code

7. Do you intend to administer immunizations while acting as the employee of a pharmacy?

Yes_____ No _____

8. Please provide the following information for the pharmacy where you are employed and intend to administer immunizations.

Pharmacy Name	Pharmacy Permit Number	Pharmacy Telephone Number	
Street Address	**City**	**State**	**Zip Code**
Prescription Department Manager Name	**License Number**	**Contact Telephone Number**	

9. Professional Practice Insurance (pharmacists only)– Do you maintain at least $200,000 of professional liability insurance?
If yes, please provide your insurance provider name, policy number, and policy expiration date. Please attach a copy of the policy to this application. **(NOTE: If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company**

Yes_____ No _____

Insurance Provider Name	Policy Number	Policy Expiration Date

The information contained herein is true and correct to the best of my knowledge, and am aware that my immunization administration certification may be suspended or revoked if I violate any pharmacy law, rule or regulation, and the Florida Board of Pharmacy Code of Conduct, and hereby affix my signature as acknowledgement and agreement of such terms.

Applicant Signature Date

_____ _____