BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CERTIFICATION OF EDUCATION AND TRAINING FOR THE REACTIVATION OF THE AUTHORIZATION TO ADMINISTER INJECTABLE MEDICATIONS, BIOLOGICALS AND IMMUNIZATIONS FOR PHARMACISTS WHOSE AUTHORIZATION EXPIRED 2 OR MORE YEARS AGO AND WHO COMPLETED A NEW TRAINING PROGRAM OTHER THAN THE APHA'S PHARMACY-BASED IMMUNIZATION DELIVERY CERTIFICATE PROGRAM

APPLICANT INFORMATION

NAME:	Last	First	Middle

AUTHORIZATION TO ADMINISTER INJECTABLES LICENSE NUMBER:	
ADDRESS:	
CITY / STATE / ZIP:	

Forward this form to the injectables education/training program provider for completion. The form must then be submitted directly to the Board of Pharmacy office by the education/training provider in an envelope with the education/training program provider's preprinted return address.

DO NOT RETURN THIS FORM TO THE APPLICANT.

Name of the education/training program provider (for the authorization to administer injectable medications, biologicals and immunizations)**:**

_____

Date of course completion for the above-noted applicant:_____
(month/day/year format)

Answer the following questions regarding the education/training program for the authorization to administer injectable medications, biologicals and immunizations program completed by the above-noted applicant:

1. Is the course provider accredited by the Accreditation Council for Pharmacy Education? ☐ Yes ☐ No

2. Was the injectables training program an evidence-based course that met the following criteria:

   a. Included study material? ☐ Yes ☐ No

   b. Included hands-on training and techniques for administration? ☐ Yes ☐ No

   c. Required testing with a passing score? ☐ Yes ☐ No

   d. Provided a minimum of 10 hours of instruction and experiential training? ☐ Yes ☐ No

   e. Complied with current guidelines and recommendations by the Centers for Disease Control and Prevention, ACPE or a similar health authority or professional body? ☐ Yes ☐ No

3. Did the course provide instruction on the following topics:

a. Basic immunology and the human immune response?	☐ Yes	☐ No
b. Mechanics of immunity, adverse effects, dose and administration schedule of available vaccines?	☐ Yes	☐ No
c. Response to an emergency situation as a result of the administration of an injectable medication, biological or immunization?	☐ Yes	☐ No
d. Administration of subcutaneous, intradermal and intramuscular injections?	☐ Yes	☐ No
e. Disease epidemiology?	☐ Yes	☐ No
f. Standards for immunization practices?	☐ Yes	☐ No
g. Vaccine-preventable diseases?	☐ Yes	☐ No
h. Recommended immunization schedules?	☐ Yes	☐ No
i. Vaccine storage and management?	☐ Yes	☐ No
j. Biohazard waste disposal and sterile techniques?	☐ Yes	☐ No
k. Informed consent?	☐ Yes	☐ No

_____ _____

Signature of Education/Training Program Representative **Date (month/day/year format)**

_____

Printed Name of Education/Training Program Representative

_____

Street Address of Education/Training Provider

_____

City, State and Zip Code of Education/Training Provider

RETURN ADDRESS:

Mailing Address:
State Board of Pharmacy
P O BOX 2649
Harrisburg PA 17105-2649

Courier Address: (UPS, FED-EX, etc.)
PA Dept of State, Bureau of Professional and Occupational Affairs
Attn: State Board of Pharmacy
2 Technology Park
Harrisburg, PA 17110-2919