California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

ADVANCED PRACTICE PHARMACIST APPLICATION INSTRUCTIONS

An Advanced Practice Pharmacist must comply with the licensure requirements may be found in Business and Professions Code section 4210 and Title 16, California Code of Regulations section 1730.1.

HOW LONG WILL IT TAKE TO PROCESS MY APPLICATION?

- Please allow the board 30 days to process your application.
- The board will notify you by mail if your application is not complete.
- Please do not contact the board to check on your application unless it has been on file for over 45 days.
- If your check has cleared your bank, the board has received your application.

QUALIFICATION OVERVIEW

To qualify for an advanced practice pharmacist license in California, you must satisfy the following requirements:

1. Hold an active pharmacist license in good standing with the California State Board of Pharmacy.

2. Meet two of these three criteria:

   A. Possess of a current certification in relevant area of practice.

   B. Completed a postgraduate residency earned in the United States through an accredited postgraduate institution.

   C. Provided 1,500 hours of clinical experience under a collaborative practice agreement or protocol to patients within 10 years of application, where clinical experience includes initiating, adjusting, modifying or discontinuing drug therapy of patients.

Any experience used to satisfy one of the three criteria above may not also be used to satisfy another of the three criteria.

WHAT MAKES AN APPLICATION COMPLETE

Please review 1-4 to ensure your application is complete before mailing it to the board.

- If your application is not complete, you will receive a “Deficiency Letter” in the mail.
- Failure to complete your application within one year from the date the board received your application, may result in your application being considered abandoned and withdrawn.

1. **APPLICATION FEE $300:** Include a check or money order for $300 made payable to the Board of Pharmacy. The application fee is nonrefundable.

2. **APPLICATION FOR ADVANCED PRACTICE PHARMACIST (17A-89)**: Please complete the entire application.

AVOID COMMON MISTAKES

- The name on the advanced practice pharmacist application must match your pharmacist license.
- Do not leave anything blank: Use "N/A" if a question doesn't apply to you.
- You must sign and date the application. An electronic or photocopy of your signature will not be accepted.

3. **MILITARY EXPEDITE:** The board will expedite review of an application that meets one of the following criteria (A, B, or C).

A. Serving in the Military: Are you currently serving in the United States military?

- ✓ Please attach some evidence of your current service, such as, a copy of your military identification.

B. Military Veteran: Have you ever served in the United States military? Were you honorably discharged?

- ✓ Please attach a copy of your DD214 with your application.

C. Active Duty Military-Spouses or Partners: If your spouse or partner is an active duty member of the U.S. Armed Forces and you hold a current license in another state, please provide the following:

- ✓ A copy of your current license in the other state, district, or territory of the United States.
- ✓ A copy of your marriage certificate, or certified declaration/registration of domestic partnership, or other evidence of legal union.
- ✓ A copy of your spouse or partner's military orders establishing duty station in California.

4. **EXPERIENCE/CERTIFICATION:** You must meet two of the following three criteria:

1. You possess of a current certification in a relevant area of practice, provide either:

   A. A copy of the certification award that includes your name, the area of specialty and date of completion, or

   B. A letter from the certification program confirming the award of the certification that includes your name, the area of specialty and the date of completion.

2. You completed a postgraduate residency earned in the United States through an accredited postgraduate institution. Provide either:

   A. A copy of the residency certificate awarded by the postgraduate institution that includes your name, the area of specialty, and dates of participation and completion, or

B. A letter of completion of a postgraduate residency, signed by the dean or residency program director of the postgraduate institution and sent directly to the board from the postgraduate institution, that lists your name, the area of specialty, and the dates of participation and completion. If you cannot satisfy this documentation requirement, the board may, for good cause shown, grant a waiver. To request such a waiver, please submit a letter with the details of your residency and an explanation in as much detail as possible, why this requirement cannot be fulfilled. Please note that additional processing time will apply to such requests.

3. You earned 1,500 hours of experience providing clinical services to patients under a collaborative practice agreement or protocol within 10 years prior to the time of application. The experience earned under a collaborative practice agreement or protocol must include initiating, adjusting, modifying or discontinuing drug therapy of patients as authorized by law. Provide all of the following:

   A. A written statement attesting under penalty of perjury that you have:
      - Earned the clinical experience within the required time frame; and
      - Provided 1,500 hours of clinical services to patients, include initiating, adjusting, modifying or discontinuing drug therapy of patients.

   B. A copy of the collaborative practice agreement or protocol.
      If a copy of the collaborative practice agreement or protocol is not available, provide a description of the collaborative practice agreement or protocol, including examples of the clinical services you provided to patients.

   C. A written statement from the supervising practitioner, program director or health facility administrator attesting under penalty of perjury that you have completed at least 1,500 hours of experience providing clinical services to patients. If you cannot provide this, the board may, for good cause shown, grant a waiver. To request such a waiver, please submit a letter with the details of your residency and an explanation in as much detail as possible, why this requirement cannot be fulfilled. Please note that additional processing time will apply to such requests.

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ADVANCED PRACTICE PHARMACIST APPLICATION

Please read the application instructions before you complete the application. Failure to provide the required information may result in the application being considered incomplete. Attach additional sheets of paper, if necessary.

The information will be used to determine if you qualify for licensure pursuant to California Business and Professions Code section 4210 and Title 16, California Code of Regulations section 1730.1. An applicant who fails to complete all the application requirements within one year after being notified by the board of deficiencies, may be deemed to have abandoned the application and may be required to file a new application, fee, and meet all the requirements which are in effect at the time of reapplication.

Military Expedite (Please check one of the following, if applicable)
_____ **MILITARY** (Are you serving in the United States military?)
_____ **VETERAN** (Have you ever served in the United States military?)
_____ **ACTIVE DUTY MILITARY** (Do you have a spouse or partner serving active duty in the military?

Applicant Information - Please Type or Print

_____ _____ _____
Full Legal Name: Last Name First Name Middle Name

_____
Previous Names (AKA, Maiden Name, Alias, etc.)

_____
*Official Mailing/Public Address of Record: Street/PO BOX City State Zip Code

_____
Residence Address: Street City State Zip Code

_____ _____ _____
Home/Cell Telephone Number Work Telephone Number Email Address

_____ _____
Date of Birth (Month/Day/Year) California Pharmacist License Number

THIS SECTION IS FOR BOARD USE ONLY

App Fee: ____ Enf. Check: ____ Photo: ____ Certification: ____ Residency Pr: ____ Practice Agr: ____	RPH Exp. Date_____ Enf 2nd Check _____	License #:_____ Date issued: _____ Date expires: _____ Issued by: _____	Receipt #: _____ Date Cashiered: _____ Amount: _____

Qualification Methods (Check all that apply)

☐ Certification in a relevant area of practice as specified in Title 16, CCR 1730.1(a)(1)

☐ Completion of postgraduate residency program as specified in Title 16, CCR 1730.1(a)(2)

☐ Experience earned providing 1,500 hours of clinical services to patients under a collaborative practice agreement or protocol within 10 years prior to the time of application as specified in Title 16, CCR 1730.1(a)(3)

Types of Services Anticipated to be Provided (Check all that apply-Voluntary)

☐ Order and interpret tests for medication management and monitoring

☐ Initiate or adjust controlled substances therapy. Enter DEA License Number: _____

Location(s) where Services are Anticipated to be Provided (Attach additional sheets, if needed) (Voluntary)

Name	Street	City	State	Zip Code
Name	Street	City	State	Zip Code
Name	Street	City	State	Zip Code
Name	Street	City	State	Zip Code

APPLICANT AFFIDAVIT

You must provide a written explanation for all affirmative answers. Failure to provide any of the requested information may result in the application being deemed incomplete. Falsification of the information on this application may constitute grounds for denial or revocation of the license.

Collection and Use of Personal Information. The California State Board of Pharmacy of the Department of Consumer Affairs collects the personal information requested on this form pursuant to Business and Professions Code sections 30 and 4000 and following and California Code of Regulations title 16, division 17. The California State Board of Pharmacy uses this information principally to identify and evaluate applicants for licensure, issue, and renew licenses, and enforce licensing standards set by law and regulation.

Access to Personal Information. You may review the records maintained by the California State Board of Pharmacy that contain your personal information, as permitted by the Information Practices Act. The official responsible for maintaining records is the Executive Officer at the board's address listed on the application. Each individual has the right to review the files or records maintained by the board, unless confidential and exempt by law.

Possible Disclosure of Personal Information. We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed under the following circumstances:

- In response to a Public Records Act request (Government Code section 6250 and following), as allowed by the Information Practices Act (Civil Code section 1798 and following);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

***Address of Record:** Once you are licensed with the board, the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 and following) and the Public Records Act (Government Code section 6250 and following) and will be available on the Internet. This is where the board will mail all official correspondence. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your address of record is not your residence address, you must also provide your residence address to the board, in which case your residence will not be available to the public.

****Disclosure of your U.S. Social Security Number or Individual Taxpayer Identification Number (ITIN) is mandatory.** Section 30 of the Business and Professions Code, section 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security number or individual taxpayer identification number. Your social security number or individual taxpayer identification number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code, or for verification of license or examination status by a licensing or examination entity, which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or individual taxpayer identification number, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

NOTICE: The State Board of Equalization and the Franchise Tax Board may share taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if your state tax obligation is not paid.

MANDATORY REPORTER

Under California law, each person licensed by the California State Board of Pharmacy is a “mandated reporter” for both child and elder abuse or neglect laws. California Penal Code section 11166 and Welfare and Institutions Code section 15630 require that all mandated reporters make a report to an agency specified in Penal Code section 11165.9 and Welfare and Institutions Code section 15630(b)(1) [generally law enforcement, state, and/or county adult protective services agencies, etc.] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child, elder, and/or dependent adult whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or elder abuse or neglect. The mandated reporter must contact by telephone immediately or as soon as possible to make a report to the appropriate agency(ies) or as soon as is practicably possible. The mandated reporter must prepare and send a written report thereof within two working days or 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of the laws above is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both that imprisonment and fine. For further details about these requirements, refer to Penal Code section 11164 and Welfare and Institutions Code section 15630 and following sections.

APPLICANT AFFIDAVIT

I, _____, hereby attest to the fact that I am the
(Print Full Legal Name)

applicant whose signature appears below. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers, and representations made in this application, including all supplementary statements. I understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____

Original Signature of Applicant Date

(please sign and date within 60 days of board receipt of the application)

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AUTHORIZATION TO RELEASE APPLICANT INFORMATION

(Optional)

The board will only disclose information pertaining to an application directly to the applicant. In order for the board to discuss the status of this application with another individual, the applicant must authorize the board in writing to discuss the application status with his or her authorized representative.

Giving consent for the board to disclose application information will authorize the board to disclose all personal information pertaining to this application. This includes, but is not limited to, social security number, date of birth, address information, all application requirement information, application approval or denied status, and any criminal conviction information the board may have on record for your application.

Applicant Consent – Must be signed and dated by the applicant for optional authorization to be valid.
As the applicant, I hereby give the board consent to communicate to the individual listed below.

I, _____, hereby give consent to
Print Name of Applicant

the California State Board of Pharmacy to disclose information about my individual application information as specified above to the following individual:

_____ _____ _____
Name Telephone Number Email Address

_____
Mailing Address – Street City State Zip Code

This consent will expire on _____, within one year, or upon licensure, whichever comes first.
Date

_____ _____
Original Signature of Applicant Date

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ADVANCED PRACTICE PHARMACIST AFFIDAVIT (Optional)

To Demonstrate Experience by Collaborative Practice Agreement or Protocol

This form is <u>not</u> required to complete the application. The form is provided to help the applicant demonstrate compliance with Title 16 California Code of Regulations section 1730.1(a)(3). To demonstrate compliance with the experience criteria, an Advanced Practice Pharmacist applicant must have provided at least 1,500 hours of clinical experience under a collaborative practice agreement or protocol within 10 years of application. The experience earned must include initiating, adjusting, modifying or discontinuing drug therapy of patients as authorized by law.

Section "A" Must be Completed by the Applicant

A. Applicant Information - Please Type or Print

_____ _____ _____
Full Legal Name: Last Name First Name Middle Name

_____
Address of Record: Street/PO BOX City State Zip Code

_____ _____ _____
Home/Cell Telephone Number Work Telephone Number Pharmacist License Number

I attest that I have: (Please initial next to each section you have completed.)

_____ Provided 1,500 hours of clinical services to patients, include initiating, adjusting, modifying or discontinuing drug therapy of patients;

_____ Earned the 1500 hours of clinical experience within the required time frame; and

_____ I have enclosed a copy of my collaborative practice agreement or protocol. If that is not available, I am providing a description of the collaborative practice agreement or protocol which includes examples of clinical services.

I declare under penalty of perjury under the laws of the State of California that the foregoing under section "A" of this form is true and correct. I understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____
Original Signature Applicant Date

Section "B" Must be Completed by the Supervising Practitioner, Program Director, or Health Facility Administrator

B. Clinical Experience - Please Type or Print

_____

Name of Applicant: Last First Middle

_____ _____ _____

Date Clinical Experience Started Date Clinical Experience Ended Number of Hours of Clinical Experience

I attest that the applicant has: (Please initial)

_____ At least 1,500 hours of experience providing clinical services to patients.

I declare under penalty of perjury under the laws of the State of California that the foregoing under section "B" of this form is true and correct. I understand that an application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____

Printed Name of Supervising Practitioner, Program Director, or Health Facility Administrator Date

_____ _____

Original Signature of Supervising Practitioner, Program Director, or Health Facility Administrator Title

_____ _____

Telephone Number Email Address