Regarding Submission Of Continuing Education Course Approval Application

The application must be received by the Board office at least thirty (30) days prior to the date of the program.

20 CSR 2220-7.080(4) states:

> (B) Continuing education program approval applications should be submitted at least thirty (30) days prior to the date of the proposed continuing education program, to ensure the program is approved for continuing education credit prior to the course being taken. Applications received less than thirty (30) days prior to the date of the program cannot be guaranteed to be approved prior to the date of the program. No application for approval of continuing education programs will be accepted if received less than ten (10) business days from the date such program is to be offered for continuing education purposes.

If you have any questions, please call the Board office at 573-751-0092.

Save Print Reset

FOR OFFICE USE ONLY
PROGRAM NUMBER
DATE APPROVED
HOURS APPROVED
DATE RECEIVED

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

APPLICATION FOR APPROVAL OF PHARMACIST CONTINUING EDUCATION PROGRAM

MAILING ADDRESS:
MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102
(573) 751-0091
EMAIL: PHARMACIST@PR.MO.GOV

DELIVERY ADDRESS:
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

This form is to be used when a provider of continuing education desires approval of a program by the Missouri Board of Pharmacy for participants to acquire continuing education hours for relicensure. This form must be submitted **thirty (30) days** prior to the initiation of the program. COMPLETE THIS FORM CAREFULLY. All information must be complete and comply with all rules and regulations of the Board of Pharmacy before approval is granted.

1. APPLICANT

NAME OF APPLICANT	TELEPHONE

APPLICANT ADDRESS (STREET, CITY, COUNTY, STATE, ZIP)	EMAIL ADDRESS

2. PROGRAM INFORMATION

PROGRAM TITLE

PROGRAM LOCATION

PROGRAM DATE AND TIME	APPROXIMATE NUMBER OF ATTENDEES

STATE OBJECTIVES

3. TOTAL NUMBER OF CONTINUING EDUCATION HOURS REQUESTED:

4. TYPE OF PROGRAM (CHECK ONE)

- ☐ LIVE LECTURE ONLY
- ☐ LIVE LECTURE WITH OPEN DISCUSSION PERIOD
- ☐ LIVE LECTURE WITH SMALL DISCUSSION OR WORKSHOP GROUPS
- ☐ WORKSHOP OR DISCUSSION GROUPS ONLY
- ☐ LABORATORY
- ☐ VIDEOTAPE
- ☐ AUDIO-CASSETTE
- ☐ JOURNAL ARTICLES
- ☐ HOME STUDY BOOK OR BOOKLET
- ☐ TELECONFERENCE/TELELECTURE/WEBCAST
- ☐ OTHER ▸ _____

5. ATTACH A RESUME OR CURRICULUM VITAE OF ALL PROGRAM PRESENTERS.

6. LIST EXACT TIME ALLOTTED FOR EACH PRESENTATION.

PRESENTATION SUBJECT	TIME (HOURS/MINUTES)

7. PROGRAM PROVIDER IS (CHECK ONE)

- ☐ COLLEGE OR SCHOOL OF PHARMACY
- ☐ OTHER POST-SECONDARY EDUCATION INSTITUTION
- ☐ PHARMACEUTICAL ASSOCIATION
- ☐ PHARMACEUTICAL MANUFACTURER
- ☐ PUBLICATION
- ☐ HOSPITAL OR HOSPITAL PHARMACY MANAGEMENT ORGANIZATION
- ☐ GOVERNMENTAL AGENCY
- ☐ INDIVIDUAL
- ☐ EDUCATIONAL CORPORATION
- ☐ OTHER, PLEASE DESCRIBE:

_____

8. GENERAL DESCRIPTION OF THE PROVIDER ORGANIZATION:

APPLICANT	DATE