MAILING ADDRESS:
Missouri Board of Pharmacy
P.O. Box 625
Jefferson City, MO 65102
(573) 751-0091
(573) 526-3464 (FAX)

DELIVERY ADDRESS:
3605 Missouri Boulevard
Jefferson City, MO 65109

PHARMACIST NOTIFICATION OF INTENT TO ADMINISTER DRUGS/VACCINES BY MEDICAL PRESCRIPTION ORDER

PHARMACIST NAME			LICENSE NO.	
HOME ADDRESS	STREET	CITY	STATE	ZIP CODE
	HOME PHONE NO.		COUNTY	
EMAIL ADDRESS				
DRUGS/VACCINES THAT WILL BE ADMINISTERED (attach separate sheet if more space is needed)				

PHARMACIST STATEMENT

1. I hold a current, unrestricted Missouri license to practice pharmacy that is not on probation.
2. I hold a current cardiopulmonary resuscitation (CPR) certification issued by the American Heart Association or the American Red Cross. **Certification Expiration Date**: _____
   (NOTE: We need the Expiration Date, not Issue Date. Failure to include correct date, will result in rejection of this form and inability to administer.)
3. I have successfully completed a certificate program in the administration of vaccines accredited by the Accreditation Council for Pharmacy Education (ACPE).

   Name of Program:_____ Date of Completion: _____
4. I have completed a minimum of two hours (0.2 CEU) of continuing education per calendar year related to administration of drugs/vaccines.
5. I have a written policy and procedure covering all aspects of the administration of drugs/vaccines as required.

By signing this form, I hereby attest that I have complied with each of the above statements, and state that I maintain copies of the certifications required in #2 and #3 above.

DO <u>NOT</u> SUBMIT COPIES OF YOUR CERTIFICATES OR CONTINUING EDUCATION WITH THIS FORM.

PHARMACIST SIGNATURE DATE