



Nuclear Pharmacist Application

Board of Pharmacy

P.O. Box 6330

Tallahassee, FL 32314-6330

Website: <https://floridaspharmacy.gov/>

Email: MQA.Pharmacy@flhealth.gov

Phone: (850) 245-4474

Fax: (850) 921-5389



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Tallahassee, FL 32314-6330
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Do Not Write in this Space
For Revenue Receipting Only

All applicants must hold a current Florida Pharmacist license that is active and in good standing.

Nuclear Pharmacist (1020) \$55.00

Total fee of \$55.00 includes the following:

Application Fee \$55.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The \$55.00 application fee is not refundable.

1. PERSONAL INFORMATION

Name: _____ Date of Birth: _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

Street/P.O. Box Apt. No. City

State ZIP Country Home/Cell Telephone

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: Male Race: Native Hawaiian or Pacific Islander Hispanic or Latino White
Female American Indian or Alaska Native Black or African American Asian
Two or More Races

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

Yes No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. LICENSURE HISTORY

A. Do you have a Florida Pharmacist (PS) license that is active and in good standing? Yes No

If "Yes," what is the license number? _____

B. Have you ever held a Nuclear Pharmacist (NP) License in Florida? Yes No

If "Yes," what was the license number? _____

3. SOCIAL SECURITY DISCLOSURE

This page is exempt from public records disclosure.

Last Name: _____

First Name: _____

Middle Name: _____

U.S. Social Security Number: _____

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. For all professions regulated under chapter (ch.) 456, Florida Statutes, the collection of Social Security numbers is required by section (s.) 456.013(1)(a), Florida Statutes.

Name: _____

4. OTHER ITEMS REQUIRED

- A. **Certificate of Training and Experience** (Experiential Training) - All applicants must have certification by their supervising pharmacist of the minimum 500 hours of training and experience as set forth in Rule 64B16-26.303(5), Florida Administrative Code (F.A.C.). All applicants must complete the Certificate of Training and Experience form found at the end of this application.
- B. **Proof of Eligibility** (Didactic Training) - All applicants must provide proof of eligibility, which consists of documentation that shows you have completed 200 clock hours of formal didactic training as set for in Rule 64B16-26.303(3), F.A.C. Acceptable forms of proof are a letter on university letterhead or a certificate of completion from the university indicating the completion of these hours.

Rule 64B16-26.303(6), F.A.C., provides that "if the didactic and experiential training required in this section has not been completed within the last seven years, you must have engaged in the lawful practice of nuclear pharmacy in another jurisdiction for at least 1,080 hours during the last seven years."

Documentation must be sent to the board office at MQA.Pharmacy@flhealth.gov, or mailed to:

Board of Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

5. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, Florida Statutes.

I am aware that my nuclear pharmacist license may be suspended or revoked if I violate any provision of chapter 456, Florida Statutes, chapter 465, Florida Statutes, and/or any laws or rules adopted pursuant thereto.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print out this application and sign it or sign digitally. MM/DD/YYYY

Complete forms must be sent directly by the supervisor to the board office at MQA.Pharmacy@flhealth.gov, or mailed to:

Board of Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258



Board of Pharmacy Certificate of Training and Experience

Part I: Applicant Information (To be completed by applicant)

Applicant Name: _____
Last First Middle
Street Address: _____
City: _____ State: _____ ZIP: _____
Home/Cell Phone: _____ Work Phone: _____

Part II: Supervisor Information (To be completed by the supervising Nuclear Pharmacist)

Supervisor Name: _____
Last First Middle
Mailing Address: _____
City: _____ State: _____ ZIP: _____
Home/Cell Phone: _____ Work Phone: _____
Pharmacist License #: _____ Nuclear Pharmacist License #: _____

Part III: Certification of Assessment and Evaluation (To be completed by the supervisor)

I certify that the applicant above completed either a minimum of 500 hours of training and experience in the handling of unsealed radioactive material within the last seven years, or 1,080 hours engaged in the lawful practice of nuclear pharmacy in another jurisdiction within the last seven years.

This training and experience or lawful practice occurred under my supervision from _____ to _____.
MM/DD/YYYY MM/DD/YYYY

If I am certifying 500 hours of training and experience, I further certify the training included the following as mandated by Rule 64B16-26.303, F.A.C.

1. Ordering, receiving, and unpackaging in a safe manner, radioactive material, including the performance of related radioactive surveys;
2. Calibrating dose calibrators, scintillation detectors, and radiation monitoring equipment;
3. Calculating, preparing, and verifying patient doses, including the proper use of radiation shields;
4. Following appropriate internal control procedures to prevent mislabeling;
5. Learning emergency procedures to safely handle and contain spilled materials, including related decontamination procedures and surveys;
6. Eluting technetium-99m from generator systems, assaying the eluate for technetium-99m, and technetium-99m labeled radiopharmaceuticals; and
7. Clinical practice concepts.

Supervisor Signature _____

Date: _____
MM/DD/YYYY