Immunization Administration Certification Application

Board *of* Pharmacy
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: https://floridaspharmacy.gov/
Email: info@floridaspharmacy.gov
Phone: (850) 245-4474
Fax: (850) 921-5389

DH-MQA 1125, Revised 04/2022, Rule 64B16-26.1032, F.A.C.

Immunization Administration Certification Application

Board of Pharmacy
P.O. Box 6330
Tallahassee, FL 32314-6330
Fax: (850) 921-5389
Email: info@floridaspharmacy.gov

Do Not Write in this Space
For Revenue Receipting Only

*All applicants **must** hold a current Florida Pharmacist, Pharmacy Intern, or Registered Pharmacy Technician license that is active and in good standing.*

Pharmacist (2201) **$55.00**

Pharmacy Intern (2202) **No Fee**

Pharmacy Technician (2208) **No Fee**

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 (Input without dashes)

_____
Business Telephone (Input without dashes)

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, Pharmacy Intern (PSI) registration, or Registered Pharmacy Technician license (RPT) that is active and in good standing?
Yes No

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

B. Have you ever held an Immunization Administration Certification in Florida? Yes No

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

Name: _____

3. TRAINING INFORMATION

Section 465.189(7), Florida Statutes (F.S.), requires any pharmacist or registered intern seeking to administer vaccines to complete a board-approved certification program of at least 20 hours.

Section 465.014(7), F.S., requires any registered pharmacy technician seeking to administer vaccines to complete a board-approved certification program of at least 6 hours.

Have you successfully completed a Florida Board of Pharmacy approved immunization administration certification program? Yes No

If "Yes," provide a copy of the certificate of completion and the following information.

Provider Name	Provider Number	Date of Completion (MM/DD/YYYY)	Certificate Number

SECTIONS 4-6 APPLY TO PHARMACISTS ONLY

4. PROTOCOL INFORMATION- THIS SECTION APPLIES TO PHARMACISTS ONLY

Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of immunization by the pharmacist. The written protocol must include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer immunizations and epinephrine. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification in immunization. Supervising physicians must review the administration of immunizations by the pharmacist(s) under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review must be outlined in the written protocol.

A pharmacist may not enter into a protocol that is to be performed while acting as employee without the written approval of the owner of the pharmacy.

Provide the following information for the physician licensed under chapter 458 or 459, Florida Statutes (F.S.), with whom you have entered into a protocol.

Attach a copy of the protocol to this application. The protocol must be signed by both the pharmacist and supervising physician.

Physician Name: _____

Physician License #: _____

_____ _____
Mailing Address City

_____ _____ _____
State ZIP Contact Telephone (Input without dashes)

5. PRACTICE INFORMATION – THIS SECTION APPLIES TO PHARMACISTS ONLY

A. Do you intend to administer immunizations while acting as the employee of a pharmacy? Yes No

If "Yes," you must provide written permission from the pharmacy owner.

B. Provide the following information for the pharmacy where you are employed and intend to administer immunizations.

Name: _____

Pharamacy Name:		
Pharmacy Permit #:		
Mailing Address:		
City:	State:	ZIP:
Pharmacy Telephone:		

Prescription Department Manager:	
License #:	Contact Telephone:

6. PROFESSIONAL PRACTICE INSURANCE- THIS SECTION APPLIES TO PHARMACISTS ONLY

Do you maintain at least $200,000 of professional liability insurance as required? Yes No

If "Yes," provide the following information:

Insurance Provider Name	Policy Number	Policy Expiration Date

Provide a copy of the professional liability insurance policy.

If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company letterhead verifying that you are covered under the company policy.

7. SUPERVISION- THIS SECTION APPLIES TO PHARMACY INTERNS AND REGISTERED PHARMACY TECHNICIANS

All interns and registered pharmacy technicians must be supervised by a licensed pharmacist whose license is clear and active and who is also certified to administer vaccines. The supervision must be at a ratio of one pharmacist to a maximum of five interns or registered pharmacy technicians, or a combination thereof.

Will you be supervised by a licensed pharmacist who has a clear and active Florida license and is certified to administer vaccines? Yes No

The Immunization Administration Certification that is added to your Registered Pharmacy Intern license will not automatically transfer over to your Pharmacist license. To have the certification added to your Pharmacist license, you will be required to apply and meet all requirements.

8. 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 sections 456.067, F.S.

I am aware that my immunization administration certification may be suspended or revoked if I violate any provision of Chapter 456, Chapter 465, 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), F.S., 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