



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



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Do Not Write in this Space
For Revenue Receiving 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? _____

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