

**DIVISION OF MEDICAL QUALITY ASSURANCE
FLORIDA BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292**



Board of Pharmacy

**Application for Registered Pharmacy Technician Training
Programs**

December 2010

Rick Scott
Governor



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Governor

Dear Florida Registered Pharmacy Technician Training Program Applicant,

Thank you for applying to become a Board of Pharmacy approved registered pharmacy technician training program in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the board) staff to process your application as soon as possible. You are encouraged to apply as early as possible, to avoid delays due to a large volume of applicants.

Florida Statutes require a completed application before your application can be reviewed. You should use the enclosed checklist to ensure that all sections of the application are complete and that the required forms are submitted. Please read these instructions carefully and fully before submitting the application. You should keep a copy of the completed application and all other materials sent to the board office for your records. When you mail the completed application, use the address noted in the instructions and on the application form. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the board staff, you are encouraged to email the board staff at mqa_pharmacy@doh.state.fl.us, or you may call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

Executive Director
Board of Pharmacy

**Please submit the following to the Florida Board of Pharmacy:
P.O. Box 6320, Tallahassee, FL 32314-6320**

Please note: Pursuant to the provisions set forth in Rule 64B16-26.351, FAC, the following programs are approved Registered Pharmacy Technician Training Programs and do not require application to the Board of Pharmacy:

1. Pharmacy technician training programs accredited on or before January 1, 2011 **by the American Society of Health-System Pharmacists (ASHP)**
2. Pharmacy technician training programs at institutions accredited on or before January 1, 2011 **by the Southern Association of Colleges and Schools (SACS)**
3. Pharmacy technician training programs approved on or before January 1, 2011 **by the Florida Commission for Independent Education (CIE)**
4. Pharmacy technician training programs provided by a **branch of the federal armed services** on or before January 1, 2011
5. Pharmacy technician training programs at institutions accredited on or before January 1, 2011 **by the Council on Occupational Education (COE)**

Application Processing

Please read all application instructions before completing your application.

Within 30 days of receipt of your application, the board office will notify you of the receipt of your application, any required documents, and your status. All sections must be **completed in full**. Failure to submit a complete application will result in a delay of processing. If you provide false information, the board may deny your application for registration. In order to complete your application, please return the following with your application:

APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to submit required documentation to the Board will result in an incomplete application. Faxed applications will not be accepted.

Non-Employer Based Programs (Complete questions 1-6 and Section I)

- _____ Evidence of licensure by the Florida Department of Education or equivalent licensing authority of another state or be within the public school system of the State of Florida
- _____ Sample Transcript and Sample Diploma
- _____ Copy of curriculum, catalog or other course descriptions
- _____ Copy of Faculty Credentials (job description, resume or curriculum vitae)

Employer Based Programs (Complete questions 1-6 and Section II)

- _____ Copy of Faculty Credentials (job description, resume or curriculum vitae)
- _____ Copy of curriculum, catalog or other course descriptions
- _____ Sample Certificate of Completion



APPLICATION FOR REGISTERED PHARMACY TECHNICIAN TRAINING PROGRAMS

Check the application types you are applying:			
<input type="checkbox"/> Non-Employer Based Registered Pharmacy Technician Training Program Complete questions 1-6 and Section I.			
<input type="checkbox"/> Employer Based Registered Pharmacy Technician Training Program Complete questions 1-6 and Section II.			
1. List Full Corporate or Legal Name of Business Entity			
2. List the Name of the Owner or Director			
3. List Mailing Address			
City	State	Zip Code	
4. List Site Address			Telephone Number
City	State	Zip Code	County
List E-Mail Address (Optional)		List Fax Number (Optional)	
5. Who should the Board contact with questions regarding this application?			
Name (Last, First)			
Address			Telephone Number
City	State	Zip Code	
E-Mail Address (Optional)		Fax Number (Optional)	
6. List the name and title of the administrative authority/authorities of the training program.			
Name (Last, First)		Position/Title	

SECTION I: NON-EMPLOYER BASED TRAINING PROGRAMS

7. Please attach evidence of licensure by the Florida Department of Education, equivalent licensing authority of another state or that you are within the public school system of the State of Florida and the sample transcript and sample diploma.

8. Please attach a copy of program curriculum, catalog or other course descriptions. Indicate what percentage (%) of the following subject matter is included in the training program:

<input type="checkbox"/> Introduction to pharmacy and health care systems	<input type="checkbox"/> Records management and inventory control
<input type="checkbox"/> Pharmacy law	<input type="checkbox"/> Interpersonal relations, communications, and ethics
<input type="checkbox"/> Pharmaceutical-medical terminology, abbreviations, and symbols	<input type="checkbox"/> Pharmaceutical calculations
	<input type="checkbox"/> Other

9. List names of faculty that will be utilized for each educational activity of the training program. Provide evidence of academic preparation or experience in the subject matter (Attach copy of job description, resume or curriculum vitae). Use additional sheets if needed.

Name (Last, First)	Position/Title

10. Has a licensed pharmacist or registered pharmacy technician with expertise in pharmacy technician practice been involved in the planning and instruction of this training program?

Yes _____ No _____	If yes, please indicate the individual name(s) and license number(s): _____ _____ _____
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Please Note: The following section is to be completed by Employer Based Training Programs Only

SECTION II: EMPLOYER BASED TRAINING PROGRAMS

11. Please attach a copy of program curriculum, catalog or other course descriptions. Indicate what percentage (%) of the following subject matter is included in the training program:

<input type="checkbox"/> Introduction to pharmacy and health care systems	<input type="checkbox"/> Records management and inventory control
<input type="checkbox"/> Pharmacy law	<input type="checkbox"/> Interpersonal relations, communications, and ethics
<input type="checkbox"/> Pharmaceutical-medical terminology, abbreviations, and symbols	<input type="checkbox"/> Pharmaceutical calculations
	<input type="checkbox"/> Other

12. Indicate the number of hours of training that is intended to be offered and length of training period.

Number of hours of training _____ Length of training period _____

13. List names of faculty that will be utilized for each educational activity of the training program. Provide evidence of academic preparation or experience in the subject matter (Attach copy of job description, resume or curriculum vitae). Use additional sheets if needed.

Name (Last, First)	Position/Title

14. Has a licensed pharmacist or registered pharmacy technician with expertise in pharmacy technician practice been involved in the planning and instruction of this training program?	
Yes _____ No _____	If yes, please indicate the individual name(s) and license number(s): _____ _____ _____
15. If the program offering includes clinical practice training in Florida, will a licensed pharmacist competent in the practice area provide supervision?	
Yes _____ No _____	If no, please explain.
16. For self-directed learning experience, please indicate the minimum number of questions to be utilized to evaluate the participant knowledge at the completion of the learning experience. Also indicate the minimum score allowed in order to receive the certificate of completion.	
Minimum number of evaluation questions _____	Minimum score allowed _____
17. Describe the course materials that will be provided to each student.	
18. Are program participants given an opportunity to evaluate learning experiences, instructional methods, facilities and resources used for the offering?	
Yes _____ No _____	If yes, please provide a sample of this evaluation. If no, please explain.
19. Has the provider established written policies and procedures for implementation of this training program?	
Yes _____ No _____	If no, please explain.
20. Has the applicant established a maintenance system of record-keeping which provides for storage of program information?	
Yes _____ No _____	If no, please explain.
21. Are records of programs maintained for three years?	
Yes _____ No _____	If no, please explain.
22. Does the applicant provide a certificate of completion to each participant?	
Yes _____ No _____	If yes, provide a sample of certificate of completion. If no, please explain.
I understand that the information provided as part of this application is accurate, and that, if approved I agree to abide by the requirements set forth in the rules established by the Board of Pharmacy in Chapter 64B16-26.351, F.A.C., for all Board approved Registered Pharmacy Technician Training Programs.	
_____ Signature Owner/Director	_____ Date