NORTH CAROLINA BOARD OF PHARMACY
CLINICAL PHARMACIST PRACTITIONER

FORM FOR NEW PHYSICIAN GROUP FOR PREVIOUSLY APPROVED CPP

FORM MUST BE TYPEWRITTEN OR NEATLY PRINTED.

I. CLINICAL PHARMACIST PRACTITIONER INFORMATION:

CPP Full Name *(first):* ____________________ *(middle):* ____________________ *(last):* ____________________

Home Address: ____

Home Phone #: ______________________________ Home Fax #: ______________________________

Date of Birth *(mm):* _____ *(dd):* _____ *(yyyy):* ________ NC CPP Approval #: ____________________

Preferred mailing address: ◯ home ◯ work

Preferred public address (will be listed on the Internet): ◯ home ◯ work

County in which practice is located: ____________________ County in which you live: ____________________

II. IN ADDITION TO THIS FORM, ALSO SUBMIT CLINICAL PHARMACIST PRACTITIONER PROTOCOL *(USING THE TEMPLATE FOUND HERE.)*

Please have the primary supervising physician initial each page and sign where indicated on the last page. Include the name of the practice; practice address, phone and fax numbers; and name(s) and NC medical license number(s) of the primary and back-up supervising physician(s). It is recommended that CPP applicants modify the yellow highlighted portions of the template (i.e. under Medical Conditions, Medication Therapy, and Tests and Monitoring), refraining from other wording changes if possible, since the wording is chosen to align with the CPP statute and rules.

III. CERTIFICATION OF UNDERSTANDING AND COMPLIANCE:

The undersigned have read this form and certify that the information contained herein is correct to the best of their knowledge.

The undersigned further certify that they have carefully read and understand the law and regulations regarding clinical pharmacist practitioners. The undersigned agree to fully comply with such statutes and regulations.

The undersigned physician accepts responsibility for the applicant's conduct as a clinical pharmacist practitioner under the physician's supervision and understands that conduct which violates the laws and regulations governing clinical pharmacist practitioners may subject the supervising physician to sanctions including suspension or revocation of the physician's license to practice medicine in North Carolina.

____________________ ______________________________
Date Clinical Pharmacist Practitioner (original signature)

Full Name (typed or printed legibly): ____________________

____________________ ______________________________
Date Primary Supervising Physician (original signature)

Full Name (typed or printed legibly): ____________________