North Carolina Board of Pharmacy

Clinical Pharmacist Practitioner Application for Approval Form Instructions

Clinical Pharmacist Practitioner Approval to Practice Process
[See Rule 21 NCAC 32T.0101 or 21 NCAC 46.3101]

APPLICATIONS ARE CONFIDENTIAL AND MAY BE DISCUSSED ONLY WITH THE CLINICAL PHARMACIST PRACTITIONER APPLICANT OR SUPERVISING PHYSICIAN

MEETING DATES AND DEADLINES

Completed application forms WITH ALL REQUIRED ATTACHMENTS must be received in the office of the Board of Pharmacy by the 15th day of each month preceding the Board meeting.The applicant is responsible for insuring that the application is completed when submitted. Board of Pharmacy meeting dates are listed on its website (www.ncbop.org). Keep a current check on the Pharmacy Board's website for any revised meeting dates.

To become a CPP, as defined, in 21 NCAC 46.3101, you must be a licensed pharmacist and have an agreement with a physician, as defined in 21 NCAC 46.3101 (6). In addition, you must have either: (1) have completed a Board of Pharmaceutical Specialties (BPS) Certification or Geriatric Certification, or the American Society of Health-Systems Pharmacists (ASHP) accredited residency program and have 2 years clinical experience **OR** (2) you must have earned a PharmD degree, have 3 years experience, and have completed a Certificate Program **OR** (3) you must have earned a BS degree, have 5 years experience, and have completed two certificate programs.

ONLY original signatures are acceptable on the application returned to the Board. Facsimiles or copies are not acceptable and will be returned.

Submit all material to: Attn: Deborah Stump, Director of Licensing
NC Board of Pharmacy
6015 Farrington Road, Suite 201
Chapel Hill, NC 27517

I. *APPLICATION FOR APPROVAL TO PRACTICE AS A CLINICAL PHARMACIST PRACTITIONER IN NORTH CAROLINA*

Applications must be reviewed and approved by the NC Board of Pharmacy. Written notification of the *FINAL* action will be mailed to the CPP's home address or preferred address approximately 7 to 10 days after approval by the NC Board of Pharmacy.

- Completed application forms must be typewritten or neatly printed.

- Please list your protocol on the Template for Clinical Pharmacist Practitioner Protocol (found here) and 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. **The protocol needs to be submitted with the application, and it should be kept on site at all times.**

- Please submit this application, the protocol, and the completed credit card authorization form (which follows this application). The Board does not accept checks. Payment by Visa, MasterCard, Discover, or American Express only. Application fee is $100 and is non-refundable.

DEA Numbers
If you are going to prescribe or order controlled substances, you must obtain a DEA number.
Contact: Drug Enforcement Administration, Registration Unit, 75 Spring Street, SW, Room 740;
Atlanta, GA 30303 (888-219-8689) or www.deadiversion.usdoj.gov - Direct Registration -
Form 224. Submit all material to: Attn: Deborah Stump, Director of Licensing
NC Board of Pharmacy
6015 Farrington Road, Suite 201
Chapel Hill, NC 27517

II. *CLINICAL PHARMACIST PRACTITIONER MODIFICATIONS*

[There is no fee required for CPP modifications.]

a. Change of status form
   i. A change of status form can be used for a change in practice site or a change in supervising physician within a previously approved physician group / protocol.
   ii. All pages must be initialed by primary supervising physician.
b. Form for new physician group for previously approved CPP
   i. The form for a new physician group for previously approved CPP can be used for addition of a new physician group and protocol by an existing CPP who was previously approved to practice with a different physician group. The signed form must be submitted along with a CPP protocol. See note in section I above regarding the use of the Template for CPP Protocol (found here.)
c. New protocol with existing physician group
   i. The CPP should submit the new protocol, with original signatures, using the protocol template (found here.) See note in section I above regarding the use of the Template for CPP Protocol.

Requests for CPP modifications may be processed administratively by the NC Board of Pharmacy in a timely manner. Administrative approval is not automatic.

A. Mail to: NC Board of Pharmacy, c/o Deborah Stump (see address above.)

B. Completed modification forms must be typewritten or printed legibly. **Incomplete forms will be returned.**

III. *ANNUAL RENEWAL*: Please refer to the FAQ (**found here**) which addresses the CPP renewal process.
You will be notified by email when it is time for you to renew.

IV. *CLINICAL PHARMACIST PRACTITIONER TERMINATION:* Please notify the Board's office in writing when a CPP terminates his/her practice as a CPP. Please include the name of the practice, practice address, name of the supervising physician(s), and effective date.

APPLICATION FOR CLINICAL PHARMACIST PRACTITIONER

North Carolina Board of Pharmacy
6015 Farrington Road, Suite 201
Chapel Hill, NC 27517

North Carolina General Statute 90-691 (a) (1) states an application may be denied or revoked if the applicant gives false information or withholds material information from the Committee in procuring or attempting to procure a license.

I hereby make application for approval to practice as a CPP in the State of North Carolina and submit the following statement concerning my age, moral character, medical education, and practice.

First Name: ____________ Middle Name: ____________ Last Name: ____________ Suffix: ________

Other names you have been known by: ______________________________
(Provide copies of official documents showing name change, i.e., a marriage certificate)

Home Address: ______________________________

Practice Address: ______________________________

Preferred Mailing Address (choose one): ◯ Practice ◯ Home

Place of Birth: ____________ Date of Birth (Month): ________ (Day): ________ (Year): ________

Email Address: ______________________________

Current Home Phone Number: ______________________________
(Enter 10-digit phone number only, with no dashes, spaces or parentheses)

Current Business Phone Number: ______________________________

Current Fax Number: ______________________________

Primary supervising physician initials: ________

REQUIREMENTS FOR CPP APPLICANTS

To become a CPP, as defined in 21 NCAC 46.3101, you must be a licensed pharmacist and have an agreement with a physician, as defined in 21 NCAC 46.3101 (6). In addition, you must have either: (1) have completed a Board of Pharmaceutical Specialties (BPS) Certification or Geriatric Certification, or the American Society of Health-Systems Pharmacists (ASHP) accredited residency program and have 2 years clinical experience **OR** (2) you must have earned a PharmD degree, have 3 years experience, and have completed a Certificate Program **OR** (3) you must have earned a BS degree, have 5 years experience, and have completed two certificate programs.

Academic Degree: ____________________ University Attended: ____________________
(BS or Doctorate in Pharmacy)

Date Degree Awarded: ____________________

Pharmacist License: ____________________ Year Original License Issued: __________
(NC License Number)

BPS or Geriatric Certification: __________ Date Completed: __________ Certificate Number: __________
(Specialty Certification)

BPS or Geriatric Certification: __________ Date Completed: __________ Certificate Number: __________
(Specialty Certification)

ASHP Residency: ____________________ Date Started: __________ Date Completed: __________
(Location)

ASHP Residency: ____________________ Date Started: __________ Date Completed: __________
(Location)

Primary supervising physician initials: ________

CERTIFICATE PROGRAMS

The Certificate Program completed must be an American Council on Pharmaceutical Education (ACPE) approved certificate program in the area of practice covered by the CPP agreement. If no ACPE Practice Certificate Program exists, an alternate certificate program may be deemed appropriate. Two Certificate Programs are required for BS degree recipients, and one is required for PharmD recipients.

(Certificate Completed)	(Identifier)	(Date Completed)
(Certificate Completed)	(Identifier)	(Date Completed)

EXPERIENCE

Five years of clinical experience is required for BS degree recipients, and 3 years is required for PharmD recipients. Different locations should be listed separately below.

Position Held (Date Started) (Date Completed)

Describe clinical experience: ____________________

Position Held (Date Started) (Date Completed)

Describe clinical experience: ____________________

Position Held (Date Started) (Date Completed)

Describe clinical experience: ____________________

Position Held (Date Started) (Date Completed)

Describe clinical experience: ____________________

Position Held (Date Started) (Date Completed)

Describe clinical experience: ____________________

Primary supervising physician initials: ________

CLAIMS INFORMATION

The Clinical Pharmacist Practitioner applicant must complete this form for **each** liability or malpractice claim. **Please print or make as many photocopies of this form as needed.** Complete one form for each claim or suit. Original signature of the clinical pharmacist practitioner applicant is required on each completed form.

1. Briefly describe the details of the allegations against you. Include the patient's name, a brief history, comments regarding the care surrounding the allegations. If suits are pending, a very brief summary of the allegations or charges must be included regardless of the litigation state. Simply stating that the charges were dismissed is inadequate. If charges were dismissed, please provide official documentation regarding the dismissal. IF THERE HAVE BEEN NO LIABILITY OR MALPRACTICE CLAIMS, ENTER *"NONE"* OR *"NO CLAIMS"* BELOW.

2. Date of the claim: ________________________

3. If an insurance carrier was involved, list the name, address and telephone number:

4. Is the claim pending? *(yes or no)*: ____________

5. Was there a judgment or settlement? *(yes or no):* ____________

6. What was the amount and date of the judgment **OR** settlement?

   Amount: ______________________

   Date: ______________________

7. Comments:

I certify that the information which I have given is correct to the best of my knowledge.

____ ______________________

Signature of Clinical Pharmacist Practitioner Applicant **(ORIGINAL SIGNATURE)** Date

Primary supervising physician initials: ________

AUTHORIZATION FOR RELEASE OF MALPRACTICE INSURANCE INFORMATION

◯ I do not have liability or malpractice insurance. *(Sign and date below and continue to next page.)*

◯ I do have liability or malpractice insurance. *(Complete malpractice statement below. Date, sign, print name, address, and telephone number and continue to next page.)*

To Whom It May Concern:

I, ____________________________ , hereby consent to the North Carolina Board of Pharmacy and its employees and/or agents examining and obtaining all records relating to my file with ______________________________ related to claims, settlements, payments and dismissals and/or any other documents maintained by this malpractice insurance carrier. I understand that by signing this document, the North Carolina Board of Pharmacy may review the information contained in these files in conjunction with the review process for my application for approval as a Clinical Pharmacist Practitioner.

Date: _______________________

____
Signature

____
(Print Name)

____
(Street Address)

____
(City, State, Zip Code)

____
(Phone Number) *enter 10 digits with no spaces, hyphens, etc.*

Primary supervising physician initials: ________

CLINICAL PHARMACIST PRACTITIONER APPLICANT BACKGROUND

Please answer the following questions (yes or no). **Provide a detailed description for any "YES" answers.**

YES / NO

1. Have you ever been convicted of a misdemeanor/felony (other than minor traffic violation) or do you have any charges pending whatsoever? Charges or convictions of DWI's should be reported.

2. Have you ever had, or do you now have any pending actions against a pharmacist license issued to you by another state? This includes consent order or agreement, revocation, suspension, restriction, probation, reprimand, censure, participation in an alternative chemical dependency program in lieu of disciplinary action, or any other disciplinary proceedings?

3. Have you ever had action involving you taken by any other governmental agency or professional licensing board?

4. Have you ever voluntarily or otherwise surrendered any license?

5. Have you been told you are impaired as a result of your use of alcohol or other substances within the past five (5) years?

6. Are you aware of any reports made about you to the National Practitioner's Data Bank or the Healthcare Integrity and Protection Data Bank (HIPDB)?

7. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended, been put on probation, or been requested to withdraw from or failed to re-apply for privileges, or been denied staff membership by a licensed hospital, clinic, managed care organization or other health care facility with an organized medical staff, in which you have trained, been a staff member or held hospital privileges?

(Questions continue on next page)

Primary supervising physician initials: ________

CLINICAL PHARMACIST PRACTITIONER APPLICANT BACKGROUND

(Continued)

YES / NO

8. Have you ever been warned by the Drug Enforcement Administration (U.S. or State), or has any portion of your controlled substance registration certificate voluntarily or otherwise, been limited, denied, revoked, suspended or surrendered? If yes, enclose explanation.

APPLICANT'S OATH

I hereby certify that I am the individual named in this Clinical Pharmacist Practitioner (CPP) registration application that all statements I have made herein are true, and that I am the original and lawful possessor of the various forms and credentials furnished to this Board as part of my application. I hereby acknowledge that falsification on any of these documents and/or making of false statements may be cause for disciplinary action against my pharmacist license and/or CPP registration.

I authorize the NC Board of Pharmacy to release information, materials, documents, orders or the like relating to me, or to this application, to any other agency of the State of North Carolina or other governmental entity licensing or regulating CPPs in any other state or territory of the United States.

Signature of Clinical Practitioner Applicant
(ORIGINAL SIGNATURE)

Date

WHILE THIS APPLICATION IS PENDING, ANY CHANGE OF INFORMATION MUST BE REPORTED TO THE BOARD OF PHARMACY IMMEDIATELY.

North Carolina Board of Pharmacy

6015 Farrington Road, Suite 201
Chapel Hill, North Carolina 27517
Phone: (919) 246-1050
Fax: (919) 246-1056
www.ncbop.org

AUTHORIZATION FOR CREDIT CARD CHARGE

THE NC BOARD OF PHARMACY ONLY ACCEPTS PAYMENT VIA VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.
NO CHECKS OR CASH ACCEPTED.

YOUR CREDIT CARD WILL BE CHARGED WHEN THIS FORM IS RECEIVED IN THE BOARD OFFICE.
ALL FEES ARE NON-REFUNDABLE.

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○

CREDIT CARD NUMBER *(VISA, MC, or DISCOVER)*: [ ] [ ] [ ] [ ]

○

CREDIT CARD NUMBER *(AMERICAN EXPRESS)*: [ ] [ ] [ ]

EXPIRATION DATE *(mm / yyyy)*: [ ] / [ ]

NAME *(exactly as it appears on the credit card)*: [ ]

BILLING ADDRESS: [ ]

ADDRESS LINE 2: [ ]

CITY: [ ] STATE: [ ] ZIP: [ ]

PHONE NUMBER *(will only be used in case of card processing problems)*: [ ]

PAYMENT FOR *(Pharmacist-Manager Change, Duplicate Certificate, List Request, etc.)*: [ ]

LICENSE / PERMIT NUMBER *(if applicable)*: [ ]

SIGNATURE: ______________________________

THIS FORM WILL BE DESTROYED IMMEDIATELY FOLLOWING PROCESSING OF PAYMENT.