California State Board of Pharmacy
1625 N. Market Blvd., Suite N-219
Sacramento, CA 95834-6237
Phone (916) 574-7900 Fax (916) 327-6308
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GAVIN NEWSOM, GOVERNOR

ADVANCED PRACTICE PHARMACIST APPLICATION INSTRUCTIONS

An Advanced Practice Pharmacist must comply with the licensure requirements may be found in Business and Professions Code section 4210 and Title 16, California Code of Regulations section 1730.1.

HOW LONG WILL IT TAKE TO PROCESS MY APPLICATION?

- Please allow the board 30 days to process your application.
- The board will notify you by mail if your application is not complete.
- Please do not contact the board to check on your application unless it has been on file for over 45 days.
- If your check has cleared your bank, the board has received your application.

QUALIFICATION OVERVIEW

To qualify for an advanced practice pharmacist license in California, you must satisfy the following requirements:

1. Hold an active pharmacist license in good standing with the California State Board of Pharmacy.

2. Meet two of these three criteria:

    A. Possess of a current certification in relevant area of practice.

    B. Completed a postgraduate residency earned in the United States through an accredited postgraduate institution.

    C. Provided 1,500 hours of clinical experience under a collaborative practice agreement or protocol to patients within 10 years of application, where clinical experience includes initiating, adjusting, modifying or discontinuing drug therapy of patients.

Any experience used to satisfy one of the three criteria above may not also be used to satisfy another of the three criteria.

CHECKLIST FOR SUBMITTING A COMPLETE APPLICATION

☐ **APPLICATION FEE $300:** Include a check or money order for $300 made payable to the Board of Pharmacy. The application fee is nonrefundable.

☐ **APPLICATION FOR ADVANCED PRACTICE PHARMACIST (17A-89)**: Please complete the entire application.

AVOID COMMON MISTAKES

- The name on the advanced practice pharmacist application must match your pharmacist license.
- Do not leave anything blank: Use "N/A" if a question doesn't apply to you.
- You must sign and date the application. An electronic or photocopy of your signature will not be accepted.

☐ **MILITARY EXPEDITE:** The board will expedite review of an application that meets one of the following criteria (A, B, or C).

A. Serving in the Military: Are you currently serving in the United States military?
   - ✓ Please attach some evidence of your current service, such as, a copy of your military identification.

B. Military Veteran: Have you ever served in the United States military? Were you honorably discharged?
   - ✓ Please attach a copy of your DD214 with your application.

C. Active Duty Military-Spouses or Partners: If your spouse or partner is an active duty member of the U.S. Armed Forces and you hold a current license in another state, please provide the following:
   - ✓ A copy of your current license in the other state, district, or territory of the United States.
   - ✓ A copy of your marriage certificate, or certified declaration/registration of domestic partnership, or other evidence of legal union.
   - ✓ A copy of your spouse or partner's military orders establishing duty station in California.

☐ **EXPERIENCE/CERTIFICATION:** You must meet two of the following three criteria:

1. You possess of a current certification in a relevant area of practice, provide either:

   A. A copy of the certification award that includes your name, the area of specialty and date of completion, or

   B. A letter from the certification program confirming the award of the certification that includes your name, the area of specialty and the date of completion.

2. You completed a postgraduate residency earned in the United States through an accredited postgraduate institution. Provide either:

   A. A copy of the residency certificate awarded by the postgraduate institution that includes your name, the area of specialty, and dates of participation and completion, or

B. A letter of completion of a postgraduate residency, signed by the dean or residency program director of the postgraduate institution and sent directly to the board from the postgraduate institution, that lists your name, the area of specialty, and the dates of participation and completion. If you cannot satisfy this documentation requirement, the board may, for good cause shown, grant a waiver. To request such a waiver, please submit a letter with the details of your residency and an explanation in as much detail as possible, why this requirement cannot be fulfilled. Please note that additional processing time will apply to such requests.

3. You earned 1,500 hours of experience providing clinical services to patients under a collaborative practice agreement or protocol within 10 years prior to the time of application. The experience earned under a collaborative practice agreement or protocol must include initiating, adjusting, modifying or discontinuing drug therapy of patients as authorized by law. Provide all of the following (A, B and C)

   A. A written statement attesting under penalty of perjury that you have:
      - Earned the clinical experience within the required time frame; and
      - Provided 1,500 hours of clinical services to patients, include initiating, adjusting, modifying or discontinuing drug therapy of patients.

   B. A copy of the collaborative practice agreement or protocol.
      If a copy of the collaborative practice agreement or protocol is not available, provide a description of the collaborative practice agreement or protocol, including examples of the clinical services you provided to patients.

   C. A written statement from the supervising practitioner, program director or health facility administrator attesting under penalty of perjury that you have completed at least 1,500 hours of experience providing clinical services to patients. If you cannot provide this, the board may, for good cause shown, grant a waiver. To request such a waiver, please submit a letter with the details of your residency and an explanation in as much detail as possible, why this requirement cannot be fulfilled. Please note that additional processing time will apply to such requests.

   Optional: You may use the Advanced Practice Pharmacist Affidavit (form 17A-E6) as a template for the written statements identified in A and C above. The affidavit must be completed and signed by both the applicant and the supervising practitioner, program director or health facility administrator to be acceptable. A copy of the collaborative practice agreement or protocol must be submitted.

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ADVANCED PRACTICE PHARMACIST APPLICATION

All information requested in this application is mandatory. Failure to provide any information will result in the application being considered incomplete. The information will be used to determine if you qualify for licensure pursuant to California Business and Professions Code section 4210 and Title 16, California Code of Regulations section 1730.1.

Please read the application instructions before you complete the application. Unless otherwise indicated, all questions on this application must be answered and signed by the applicant. If not applicable, indicate N/A. Attach additional sheets of paper, if necessary.

Military Expedite ☐ **MILITARY** (Are you serving in the United States military?)
☐ **VETERAN** (Have you ever served in the United States military?)
☐ **ACTIVE DUTY MILITARY** (Spouse or Partner)

Applicant Information - Please Type or Print

Full Legal Name: Last	First	Middle	Former	CA Pharmacist License No:

*Official Mailing/Public Address of Record: Number	Street	City	State	Zip Code

Residence Address: (if different from above) Number	Street	City	State	Zip Code

Home/Cell Telephone Number:	Work Telephone Number:
( )	( )
Email address:	Date of Birth:

Qualification Methods (Check all that apply)

☐ Certification in a relevant area of practice as specified in Title 16, CCR 1730.1(a)(1)

☐ Completion of postgraduate residency program as specified in Title 16, CCR 1730.1(a)(2)

☐ Experience earned providing 1,500 hours of clinical services to patients under a collaborative practice agreement or protocol within 10 years prior to the time of application as specified in Title 16, CCR 1730.1(a)(3)

Type of Services anticipated to be provided: (Check all that apply) (Voluntary)

☐ Order and interpret tests for medication management and monitoring

☐ Initiate or adjust controlled substances therapy
Enter DEA licensure number:

Location(s) where services are anticipated to be provided: (Attach additional sheets, if needed) (Voluntary)

Name	Street Address	City	State	Zip
Name	Street Address	City	State	Zip
Name	Street Address	City	State	Zip
Name	Street Address	City	State	Zip

Do No Write Below This Line

Enf. 1st Check ☐ Photo ☐ Certification ☐ Residency Program ☐ Practice Agreement ☐	RPH Exp. Date _____ Enf 2nd Check ☐	License #. _____ Date issued _____ By: _____	Receipt # _____ Amount _____ Date Cashiered _____

APPLICANT AFFIDAVIT

Falsification of the information on this application may constitute grounds for denial or revocation of the license.

Mandatory Submission: Submission of the requested information is mandatory unless otherwise indicated. Failure to provide any of the required information may result in the application being rejected as incomplete.

Collection and Use of Personal Information: The California State Board of Pharmacy of the Department of Consumer Affairs collects the personal information requested on this form pursuant to Business and Professions Code sections 4200, 4210 and Title 16 California Code of Regulations sections 1730.1. The California State Board of Pharmacy uses this information to identify and evaluate applicants for licensure, issue and renew licenses, and enforce licensing standards set by law and regulation.

Access to Personal Information: You have the right to review the records maintained by the California State Board of Pharmacy that contain your personal information, as permitted by the Information Practices Act, unless confidential and exempt by law. The official responsible for maintaining records is the Executive Officer at the board's address listed on the application.

Possible Disclosure of Personal Information: We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed under the following circumstances:

- In response to a Public Records Act request (Government Code section 6250 and following), as allowed by the Information Practices Act (Civil Code section 1798 and following);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

Once you are licensed with the board, the official mailing/public address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 et seq.) and the Public Records Act (Government Code section 6250 et seq.) and will be available on the Internet. This is where the board will mail as your address of record all official correspondence. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your official public address of record is not your residence address, you must also provide your residence address to the board, in which case your residence will not be available to the public.

MANDATORY REPORTER

Under California law, each person licensed by the California State Board of Pharmacy is a "mandated reporter" for both child and elder abuse or neglect laws.

California Penal Code Section 11166 and Welfare and Institutions Code section 15630 require that all mandated reporters make a report to an agency specified in Penal Code section 11165.9 and Welfare and Institutions Code section 15630(b)(1) [generally law enforcement, state, and/or county adult protective services agencies, etc.] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child, elder and/or dependent adult whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or elder abuse or neglect. The mandated reporter must contact by telephone immediately or as soon as possible, to make a report to the appropriate agency(ies) or as soon as is practicably possible. The mandated reporter must prepare and send a written report thereof within two working days or 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of the laws above is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both that imprisonment and fine. For further details about these requirements, refer to Penal code section 11164 and Welfare and Institutions Code section 15630, and the following sections.

APPLICANT AFFIDAVIT

(must be signed and dated by the applicant)

I, _____ , hereby attest to the fact that I am the applicant whose signature
(Print Full Legal Name)

appears below. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____

Original Signature of Applicant Date

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To Demonstrate Experience by Collaborative Practice Agreement or Protocol

This form is <u>not</u> required to complete the application. The form is provided to help the applicant demonstrate compliance with Title 16 California Code of Regulations section 1730.1(a)(3). To demonstrate compliance with the experience criteria, an Advanced Practice Pharmacist applicant must have provided at least 1,500 hours of clinical experience under a collaborative practice agreement or protocol within 10 years of application. The experience earned must include initiating, adjusting, modifying or discontinuing drug therapy of patients as authorized by law.

This Section to Be Completed by the Applicant

A. Applicant Information (Please print clearly or type)

Name of Applicant Last	First	Middle	Pharmacist License #

Address of Record Number and Street	City	State	Zip Code

Home/Cell Telephone Number	Work Telephone Number

I attest that I have:

_____ Initials — Provided 1,500 hours of clinical services to patients, include initiating, adjusting, modifying or discontinuing drug therapy of patients;

_____ Initials — Earned the 1500 hours of clinical experience within the required time frame; and

_____ Initials — I have enclosed a copy of my collaborative practice agreement or protocol. If that is not available I am providing a description of the collaborative practice agreement or protocol which includes examples of clinical services.

I declare under penalty of perjury under the laws of the State of California that the foregoing under section "A" of this form is true and correct. I understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____
Original Signature of Applicant Date

This Section to Be Completed by the Supervising Practitioner, Program Director, or Health Facility Administrator

B. CLINICAL EXPERIENCE: (Please print clearly or type)

Name of Applicant Last	First	Middle

From: (mm/dd/yyyy)	To: (mm/dd/yyyy)	Number of Hours of Clinical Service

I attest that the applicant has:

_____ Initials — At least 1,500 hours of experience providing clinical services to patients

I declare under penalty of perjury under the laws of the State of California that the foregoing under section "B" of this form is true and correct.

_____
Original Signature of Supervising Practitioner, Program Director, or Health Facility Administrator Date

_____
Printed Name of Supervising Practitioner, Program Director, or Health Facility Administrator Title