

# **Attachment 6**

## **XIV. Discussion and Consideration of Board Regulations Regulation Timeline**

### **b. Discussion of Board Regulations – Timeline**

#### **5. Board-Approved Regulations – Board Staff Drafting Initial Rulemaking Documents**

- i. California Code of Regulations Section, Title 16, 1793.5,  
Pharmacy Technician Application

**Timeline:**

Approved by Board: November 6, 2025

Board staff are drafting rulemaking documents.

- ii. California Code of Regulations, Title 16, Section 1711, Quality  
Assurance Timeline:

Approved by the Board: April 29, 2026

Board staff are drafting rulemaking documents.

**Pharmacy Technician  
Application  
16 CCR § 1793.5**



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Business, Consumer Services and Housing Agency  
 Department of Consumer Affairs  
 Gavin Newsom, Governor



## PHARMACY TECHNICIAN APPLICATION

Please ~~Read~~ Read the application instructions prior to completing the ~~before you complete~~ the application. Failure to provide the requested information may result in the application being considered incomplete.

~~Attach additional sheets on paper if necessary.~~

~~\_\_\_\_\_ Military (Are you currently serving in the United States military?)~~

~~\_\_\_\_\_ Veteran (Have you ever served in the United States military?)~~

**MILITARY EXPEDITE** (Please ~~check~~ check one of the following, if applicable)

\_\_\_\_\_ Military: Currently serving in the United States military.

~~\_\_\_\_\_ Veteran:~~ \_\_\_\_\_ Veteran: (Have you ~~s~~ served as an active duty member of the United States military and been honorably discharged?)

~~\_\_\_\_\_ Active Duty Military Spouse or Domestic Partner:~~ \_\_\_\_\_ Active Duty Military Spouse or Domestic Partner: (Are you ~~m~~ married to, or in a domestic partnership or other legal union with, an active duty member of the United States military who is assigned to a duty station in California under official active duty military orders and ~~do~~ do you hold a current license in another state, district, or territory of the United States in the profession for which you seek licensure?)

**REFUGEE EXPEDITE** (Please ~~check~~ check one of the following, if applicable)

~~\_\_\_\_\_ Refugee pursuant to section 1157 of title 8 of the United States Code;~~

~~\_\_\_\_\_ Refugee granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to section 1158 of title 8 of the United States Code;~~ \_\_\_\_\_ Refugee granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to section 1158 of title 8 of the United States Code; ~~or,~~

~~\_\_\_\_\_ Refugee with a special immigrant visa that has been granted a status pursuant to section 1244 of Public Law 110-181, Public Law 109-163, or section 602(b) of title VI of division F of Public Law 111-8.~~

TAPE A COLOR  
 PASSPORT STYLE 2"X2"  
 PHOTO TAKEN WITHIN  
 60 DAYS OF THE FILING  
 OF THIS APPLICATION  
**NO POLAROID OR  
 SCANNED IMAGES**

PHOTO MUST BE ON  
 PHOTO QUALITY PAPER

### 1. Applicant Information - Please Type or Print in blue or black ink.

Full Legal Name - Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Previous Names (AKA, Maiden Name, Alias, etc.) \_\_\_\_\_

\*Official Mailing/Public Address of Record (Street Address, PO Box #, etc.) City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Residence Address (If different from above) Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Driver's License Number \_\_\_\_\_ State \_\_\_\_\_ Email Address \_\_\_\_\_

Date of Birth (Month/Day/Year) \_\_\_\_\_ \*\*US Social Security # or Individual Tax ID # \_\_\_\_\_

### THIS SECTION IS FOR BOARD USE ONLY

App Fee: _____	FP Card/Fee: _____	<b>Issuance</b>	<b>CASHIERING ONLY</b>	
Enf. Check: _____	LS: _____	License #	<i>APPLICATION FEE</i>	
Photo: _____	DOJ Date _____	Date Issued	Receipt #:	
Qualify Code: _____	FBI Date _____	Date Expires	Date Cashiered:	
School Code: _____	Self-Query _____		Amount:	

**APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS**

**REMINDER:** The Self-Query Report from the National Practitioner Data Bank (NPDB) must be submitted with your application.

**2. Mandatory Education**

Please indicate Check one to identify how you satisfy comply with the mandatory education requirement, ~~in Business and Professions Code section 4202(a).~~ [BPC §4202(a)] Include with the application the required supporting document as specified in the application instructions.

United States ~~H~~high school graduate  
~~Attach an official embossed transcript or notarized copy of your high school transcript, or certificate of proficiency.~~

Graduate of ~~f~~Foreign ~~e~~Equivalent to United States ~~h~~High ~~s~~School  
~~Attach a notarized copy of your foreign secondary school transcript or diploma along with a certified translation of the document if it is not in English.~~

~~Completed~~ Possess a general educational development certificate equivalent.  
~~Attach an official transcript in a sealed envelope or notarized copy of your test results or certificate of proficiency.~~

**3. Pharmacy Technician Qualifying Method (check one box)**

Please ~~check one of the boxes below~~ to identify how you qualify ~~in order~~ to apply for a pharmacy technician license, ~~pursuant to section 4202(a)(1) through of the Business and Professions Code.~~ Include with the application the required supporting document as specified in the application instructions.

~~Attached is the Affidavit of Completed Coursework or Graduation for:~~ Associate degree in Pharmacy Technology, Training Course, or Graduate of a school of pharmacy.

Obtained an associate's degree in pharmacy technology. [BPC §4202(a)(1)]

~~Attached is a copy of PTCB or ExCPT certificate~~

Completed a pharmacy technician training program accredited by the ASHP. [BPC §4202(a)(2) & 16 CCR §1793.6(a)]

~~Attached is a copy of military training DD214~~

Completed a pharmacy technician training program provided by a branch of the federal armed services. [BPC §4202(a)(2) & 16 CCR §1793.6(b)]

Completed a course of training that satisfies the requirements of 16 CCR §1793.6(c). [BPC §4202(a)(2) & 16 CCR §1793.6(c)]

Graduated from a school of pharmacy recognized by the Board. [BPC §4202(a)(3)]

Certified by the Pharmacy Technician Certification Board or the National Healthcareer Association. [BPC §4202(a)(4) & 16 CCR §1793.65]

**4. License Information**

List all state(s) where you hold or held a license as a pharmacy technician, pharmacist, intern pharmacist, and/or another health care professional license, including California. Attach an additional sheet if necessary.

**State    Registration Number    Active or Inactive    Issued Date    Expiration Date**

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Are you currently or have you previously been licensed as a pharmacist, intern pharmacist, pharmacy technician, any type of designated representative, and/or other healthcare professional?

**Yes    No    If Yes,** List the following for all state(s), including California. Attach additional sheets if necessary.

<u>State</u>	<u>Type of License</u>	<u>License Number</u>	<u>Active or Inactive</u>	<u>Issued Date</u>	<u>Expiration Date</u>

**Self-Query Report by the National Practitioner Data Bank (NPDB)**

Attached is the original sealed envelope containing my Self-Query Report from NPDB. (This must be submitted with your application in a sealed envelope.)

**APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS.**

**5. Ownership Information** –For any affirmative answer, attach a statement of explanation including company name, type of license, license number, and identify the state, territory, foreign country, or other jurisdiction where licensed.

1. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator, or medical director on a license to conduct a pharmacy, wholesaler, third-party logistics provider, or any other entity licensed in any state, territory, foreign country, or other jurisdiction?

Yes \_\_\_\_\_ No \_\_\_\_\_ If “yes,” attach a statement of explanation.

Do you have or have you had any direct or indirect beneficial interest in, or do you have or have you previously exercised management and control over and/or served as an officer, director, manager and/or member of an LLC, partner, stockholder, trustee, professional director, or administrator for, a pharmacy, clinic, wholesaler, third-party logistics provider, or outsourcing facility licensed in California or any other state, jurisdiction, territory, or country?

**Yes    No    If Yes,** list all current and past licenses. Attach additional sheets if necessary.

<u>Name of Facility</u>	<u>License Type and Number</u>	<u>State Issued</u>

**6. Disciplinary History -**

The following questions pertain to a license sought or held in California or any other state, jurisdiction, territory, or foreign country, or other jurisdiction. For any affirmative answer, attach a statement of explanation including type of license, license number, type of action, date of action, and identify the state, territory, foreign country, or other jurisdiction.

- ~~2. Have you ever had an application for pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration denied? Yes \_\_\_ No \_\_\_ If "yes," attach a statement of explanation.~~
- ~~3. Have you ever had a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it? Yes \_\_\_ No \_\_\_ If "yes," attach a statement of explanation.~~
- ~~4. Have you ever had a pharmacy, wholesaler, third-party logistics provider, and/or any other entity license denied, suspended, revoked, placed on probation, or had other disciplinary action taken? Yes \_\_\_ No \_\_\_ If "yes," attach a statement of explanation.~~
- A. Have you ever had an application and/or license for a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational or registration denied, suspended, revoked, placed on probation, or had other disciplinary action taken against it?  
Yes \_\_\_ No \_\_\_ If Yes, provide a statement of explanation including the type of application and/or license type and number, type of action, date of action, and identify the state, jurisdiction, territory, or country.

- B. Do you have or have you had any direct or indirect beneficial interest in, or have you exercised management and control over and/or served as an officer, director, manager and/or member of an LLC, partner, stockholder, trustee, professional director, or administrator for a California and/or nonresident pharmacy, clinic, wholesaler, third-party logistics provider, outsourcing facility and/or any other facility whose license has been denied, suspended, revoked, placed on probation, or had other disciplinary action taken against it?

Yes \_\_\_ No \_\_\_ If Yes, list all current and past licenses. Attach additional sheets if necessary.

<u>Name of Facility</u>	<u>License Type and Number</u>	<u>State Issued</u>

**7. Practice Impairment or Limitation**

~~The board will make an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the board is unable to make a determination based on the information provided, the board may require an applicant to be examined by one or more physicians or psychologists, at the board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.~~

~~5. Do you have an emotional, mental, or behavioral disorder that may impair your ability to practice safely?~~

~~Yes \_\_\_ No \_\_\_ If "yes," attach a statement of explanation.~~

~~6. Do you have a physical condition that may impair your ability to practice safely?~~

Yes \_\_\_\_\_ No \_\_\_\_\_ If "yes," attach a statement of explanation.

~~7. Do you have any other condition that may in any way impair or limit your ability to practice safely?~~

~~Yes \_\_\_\_\_ No \_\_\_\_\_ If "yes," attach a statement of explanation.~~

~~8. Have you participated in, been enrolled in, or required to enter into any drug, alcohol, or other substance abuse recovery program?~~

~~Yes \_\_\_\_\_ No \_\_\_\_\_ If "yes," attach a statement of explanation.~~

~~9. If you answered "Yes" to questions 5 through 8 above, have you received treatment or participated in any program that improves your ability to practice safely?~~

~~Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_ If "yes," attach a statement of explanation.~~

The board Board makes an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the Board is unable to make a determination based on the information provided, the Board may require an applicant to be examined by one or more physicians or psychologists, at the Board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.

A. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice pharmacy in a competent, ethical, and professional manner?

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, provide statement of explanation.

## **8. APPLICANT ADVISEMENTS AND AFFIDAVIT**

~~Provide a written explanation for all affirmative answers. Failure to do so may result in this application being deemed incomplete. Falsification of the information on this application may constitute ground for denial or revocation of the license.~~

**All items of information requested in this application are mandatory.** Provide a signed and dated written explanation for all affirmative answers. Failure to provide any of the requested information may result in the application being deemed as incomplete and a deficiency notice being issued. An applicant who fails to complete all application requirements within 60 days after being notified by the bBoard of deficiencies in his or her their file may be deemed to have abandoned the application and may be required to file a new application, fee (as required by 16 CCR section 1749), and meet all the requirements in effect at the time of reapplication. [16 CCR §1706.2]

**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, sSections 30 and cChapter 9 of division 2, and California Code of Regulations, t title 16, division 17. The California State Board of Pharmacy uses this information principally 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 may review the records maintained by the California State Board of Pharmacy that contain your personal information, as permitted by the Information Practices Act. The official responsible for maintaining records is the Executive Officer at the ~~h~~Board's address listed on the application. Each individual has the right to review the files or records maintained by the ~~h~~Board, ~~unless confidential and exempt to the extent permitted by law.~~

**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 in the following circumstances:

- In response to a Public Records Act request (Government Code ~~s~~Sections ~~6250 and following~~7920.000-7931.000), as allowed by the Information Practices Act (Civil Code ~~s~~Sections ~~1798-1798.78 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.

**\*Address of Record:** Once you are licensed with the ~~h~~Board, the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code sections ~~1798-1798.78 and following~~) and the Public Records Act (Government Code ~~s~~Sections ~~6250-7920.000-7931.000 and following~~) ~~and will be available on the Internet.~~ This is where the ~~h~~Board will mail all 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 address of record is not your residence address, you must also provide your residence address to the ~~h~~Board, in which case your residence address will not be available to the public.

**\*\*Disclosure of your U.S. social security number or individual taxpayer identification number is mandatory.** Section 30 of the Business and Professions Code, ~~s~~Section 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security number or individual taxpayer identification number. Your social security number or individual taxpayer identification number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family ~~Law~~ Code, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or individual taxpayer identification number, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

NOTICE: The State Board of Equalization and the Franchise Tax Board may share taxpayer information with the ~~h~~Board. You are obligated to pay your state tax obligation. This application may be denied, or your license may be suspended if your state tax obligation is not paid.

### 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 ~~S~~section 11166 and Welfare and Institutions Code ~~S~~section 15630 require that all mandated reporters make a report to an agency specified in Penal Code ~~S~~section 11165.9 ~~and or~~ Welfare and Institutions Code ~~S~~section 15630(b)(1), as applicable, [generally law enforcement, state and/or county adult protective services agencies, etc.]

whenever the mandated reporter, in the licensee's professional capacity or within the scope of the licensee's 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~~ make an initial report by telephone immediately or as soon as practicably possible, ~~to make a report to the appropriate agency(ies) or as soon as practicably possible.~~ The mandated reporter and must prepare and send a written report thereof within a specified timeframe thereafter. two working days or 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of the laws referenced 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 et seq. and Welfare and Institutions Code Section 15630, and following sections et seq.

**APPLICANT AFFIDAVIT**

Must be signed and dated by the applicant. Must be received by the Board within 60 days of signing.

I, \_\_\_\_\_, hereby attest to the fact that I am the  
(Print Full Legal Name)

applicant whose signature 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

~~(please sign and date within 60 days of board receipt of the application)~~

\_\_\_\_\_  
Date



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 Department of Consumer Affairs  
 Gavin Newsom, Governor



**AFFIDAVIT OF COMPLETED COURSEWORK OR GRADUATION FOR PHARMACY TECHNICIAN**

**Instructions:** ~~The Director, Registrar, or Pharmacist must complete and sign this form certifying the identified individual has met the specified requirements in section 4202 of the Business and Professions Code and, if applicable, board regulations. All dates must include the month, day, and year for the form to be accepted.~~

This is to certify that \_\_\_\_\_ has  
 \_\_\_\_\_  
 Print Full Name of Applicant

\_\_\_\_\_ Completed a pharmacy technician training program accredited by the American Society of Health-  
 System Pharmacists (ASHP) as specified in Title 16, California Code of Regulations, Section  
 1793.6(a) on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_ (completion date must be included)

\_\_\_\_\_ Completed a training course that provided at least 240 hours of instruction as specified in Title 16,  
 California Code of Regulations, Section 1793.6(c) on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_ (completion date must be included)

\_\_\_\_\_ Completed an Associate Degree in Pharmacy Technology and was conferred on  
 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_ (graduation date must be included)

\_\_\_\_\_ Graduated from a school of pharmacy accredited or granted candidate status by the Accreditation  
 Council for Pharmacy Education (ACPE). The degree of Bachelor of Science in Pharmacy or the  
 degree of PharmD was conferred on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_ (graduation date must be included)

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of  
 the above: \_\_\_\_\_

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Name of Pharmacy Technician Training Program, Course, or School of Pharmacy \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Print Name of Director, Registrar, or Pharmacist \_\_\_\_\_

Email \_\_\_\_\_ Pharmacy/Pharmacist License Number \_\_\_\_\_

**Affix school seal here or Attach a business card of the pharmacist who provided the training pursuant to  
 section 1793.6(c) of Title 16, California Code of Regulations here. The pharmacist's license number shall be  
 listed.**

**AFFIDAVIT OF COMPLETED TRAINING COURSE OR PHARMACY TECHNICIAN TRAINING PROGRAM**

**Instructions:** The Director, Registrar, or Pharmacist must complete and sign this form certifying the identified individual has met the specified requirements in Business and Professions Code section 4202 and, if applicable, Board regulations as listed in section 1 or 2 below. **All dates must include the month, day, and year for the form to be accepted.**

This is to certify that \_\_\_\_\_ has completed the following:  
\_\_\_\_\_ Print Full Name of Applicant

1. Business and Professions Code section 4202(a)(1) Pharmacy Technician Qualification:  
Obtained an associate’s degree in pharmacy technology.

**Date of Completion:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

2. Business and Professions Code section 4202(a)(2) and Title 16, Division 17, Article 11, California Code of Regulations (CCR) section 1793.6 Pharmacy Technician Training Program: (Check one)

CCR 1793.6(a): Completed a pharmacy technician training program accredited by the American Society of Health-System Pharmacists (ASHP).

**Date of Completion** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

CCR 1793.6(c)(1) and (2): Completed a training course that (1) provided a training period of at least 240 hours of instruction covering the knowledge and understanding as specified in 1793.6(c)(1)(A-G); and (2) satisfied the notification and other requirements set forth in 1793.6(c)(2)(A-D).

**Date of Completion:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

Name of Pharmacy Technician Training Course/Program: \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Print Name of Director, Registrar, or Pharmacist \_\_\_\_\_

Email \_\_\_\_\_ Pharmacy/Pharmacist License Number \_\_\_\_\_

I hereby certify under the laws of the State of California to the truth and accuracy of the above:

Signed \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**Affix school seal here or attach a business card of the pharmacist who provided the training.**

# **Quality Assurance**

**16 CCR § 1711**

**TITLE 16. PROFESSIONAL AND VOCATIONAL REGULATIONS  
DIVISION 17.**

**BOARD OF PHARMACY  
DEPARTMENT OF CONSUMER AFFAIRS**

**PROPOSED REGULATORY LANGUAGE:**

**Quality Assurance Programs.**

<b>Legend:</b>	Added text is indicated with an <u>underline</u> . Omitted text is indicated by (* * * *) Deleted text is indicated by <del>strikeout</del> .
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**Amend section 1711 of Division 17 of Title 16 of the California Code of Regulations to read as follows:**

**§ 1711. Quality Assurance Programs.**

(a) Each pharmacy shall establish or participate in an established quality assurance program ~~that documents and assesses medication errors to determine cause and an appropriate response as part of a mission to improve the quality of pharmacy service and prevent errors.~~ The program shall, at a minimum, include the following:

- (1) All medication errors discovered shall be subject to a quality assurance review.
- (2) Assessment and documentation of each medication error to determine the potential causes, contributing factors and appropriate responses to minimize and mitigate future errors.
- (3) Aggregate and analyze medication errors identified pursuant to paragraph (1) to prepare reports that assess medication error trends, causes and contributing factors, and establish pharmacy systems or workflow processes that minimize or mitigate future errors.

Nothing in this section shall supersede, or be construed as a substitution for, the requirement that community pharmacies report medication errors to an entity approved by the Board pursuant to Business and Professions Code (BPC) section 4113.1.

(b) For purposes of this section, “medication error” ~~means any variation from a prescription or drug order not authorized by the prescriber, as described in Section 1716. Medication error, as defined in the section, does not include any variation that is corrected prior to furnishing the drug to the patient or patient's agent or any variation allowed by law~~ has the same meaning as set forth in BPC section 4113.1.

(c) Policies and procedures: the pharmacy shall establish policies and procedures that define the quality assurance program requirements. At a minimum, the policies and procedures must establish the following:

(1) Each quality assurance program shall be managed in accordance with written policies and procedures maintained in the pharmacy in an immediately retrievable form. The time frame within which a medication error review must commence. An investigation of each medication error shall commence as soon as is reasonably possible after discovery, but in no case later than 2 business days from the date the medication error is discovered.

(2) When a pharmacist determines that a medication error has occurred, a pharmacist shall as soon as possible: The provisions for notification of impacted parties (including the patient or the patient's agent, and the prescriber) of the medication error and at minimum, how to avoid injury or mitigate the error.

(A) Communicate to the patient or the patient's agent the fact that a medication error has occurred and the steps required to avoid injury or mitigate the error.

(B) Communicate to the prescriber the fact that a medication error has occurred.

(3) The Documentation of communication requirement to impacted parties as required in paragraph (2) of this subdivision shall only apply to medication errors if the drug was administered to or by the patient, or if the medication error resulted in a clinically significant delay in therapy.

(4) If a pharmacist is notified of a prescription error by the patient, the patient's agent, or a prescriber, the pharmacist is not required to communicate with that individual as required in paragraph (2) of this subdivision. The information required to be documented in an individual medication error report and aggregate medication error report, including factual findings and actions taken in response.

(5) The frequency with which aggregate medication error reports are created.

(6) The frequency with which the pharmacist-in-charge (PIC) is required to review individual and aggregated medication error reports. At a minimum, the PIC shall review and sign each aggregated medication error report annually.

(7) The process the pharmacy will use to communicate all aspects of its quality assurance program to pharmacy personnel, including communication of process improvements, and how to minimize or mitigate medication errors.

(d) Each pharmacy shall use the findings of its quality assurance program to develop pharmacy systems and workflow processes designed to prevent medication errors. An investigation of each medication error shall commence as soon as is reasonably

~~possible, but no later than 2 business days from the date the medication error is discovered. All medication errors discovered shall be subject to a quality assurance review.~~Records:

- (1) Individual and aggregate medication error reports shall be retained and immediately retrievable for at least three years from the date created.
  - (2) Any medication error report related to the use of a licensed automated drug delivery system must also be submitted to the Board within 30 days of creation of the report.
  - (3) Medication errors related to the use of an automated unit dose delivery system as described in Business and Professions Code section 4427.2 (i) must also be submitted as an aggregate medication error report upon annual renewal of the facility license.
  - (4) Medication errors related to the use of an unlicensed automated drug delivery system used as technology within the licensed pharmacy as described in Business and Professions Code section 4427.2 (j) are required to be retained by the facility and not submitted to the Board.
- ~~(e) The primary purpose of the quality assurance review shall be to advance error prevention by analyzing, individually and collectively, investigative and other pertinent data collected in response to a medication error to assess the cause and any contributing factors such as system or process failures. A record of the quality assurance review shall be immediately retrievable in the pharmacy. The record shall contain at least the following:~~
- ~~(1) The date, location, and participants in the quality assurance review;~~
  - ~~(2) The pertinent data and other information relating to the medication error(s) reviewed and documentation of any patient contact required by subdivision (c);~~
  - ~~(3) The findings and determinations generated by the quality assurance review; and,~~
  - ~~(4) Recommend changes to pharmacy policy, procedure, systems, or processes, if any.~~

~~The pharmacy shall inform pharmacy personnel of changes to pharmacy policy, procedure, systems, or processes made as a result of recommendations generated in the quality assurance program.~~Mitigation:

- ~~(f) The record of the quality assurance review, as provided in subdivision (e) shall be immediately retrievable in the pharmacy for at least one year from the date the record was created. Any quality assurance record related to the use of a licensed automated drug delivery system must also be submitted to the board within 30 days~~

~~of completion of the quality assurance review and any facility with an unlicensed automated drug delivery system must report the quality assurance review to the Board at the time of annual renewal of the facility license.~~

~~(g)~~ The pharmacy's compliance with this section will be considered by the board as a mitigating factor in the investigation and evaluation of a medication error.

~~(hf)~~ Contracting: Nothing in this section shall be construed to prevent a pharmacy from contracting or otherwise arranging for the provision of personnel or other resources, by a third party or administrative offices, with such skill or expertise as the pharmacy believes to be necessary to satisfy the requirements of this section.

~~(g)~~ Pharmacies located in the state and operated under common ownership may satisfy the requirements of this section pursuant to policies and procedures that allow for joint and collaborative review, analysis and communication.

Authority cited: Section 4005, Business and Professions Code; ~~and Section 2 of Chapter 677, Statutes of 2000.~~ Reference: Sections 4125 and 4427.7, Business and Professions Code.