Print Form

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

Revised June 2016

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 protocols on the Template for Clinical Pharmacist Practitioner Protocol and have the supervising physician initial the form. If additional pages are required, please have the supervising physician initial all pages. ***This needs to be submitted with the application and it should be kept on site at all times.***

- Please include the name of the practice, practice address, name of the supervising physician, and 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 CHANGE OF STATUS FORM*
[All pages must be initialed by supervising physician.]

Change of status form is needed for:
* Addition of practice sites
* Addition/Change of supervisor at previously approved site

Requests for addition of practice sites and supervising physicians 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 change of status 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.

APPLICATION FOR CLINICAL PHARMACIST PRACTITIONER

Print Form

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: _____

Print Form

DESCRIPTION OF PRACTICE STRUCTURE

A. Please describe, in detail, the structure of your practice and relationship with your supervising physician. Examples may include whether you and your supervising physician are employed within the same practice, whether you accept referrals from other physicians within or outside your practice and your supervising physician is a clinic or program director, or whether you have your own freestanding practice and accept referrals from outside supervising physicians.

B. Describe/Check all that apply:

- ☐ CPP and Supervising Physician, same practice
- ☐ CPP accepts referrals from other physicians (within or outside of CPP's practice) and is supervised by clinic, program, or medical director
- ☐ University/Academic setting
- ☐ Hospital setting
- ☐ CPP freestanding practice receiving referrals from outside physicians

C. Description of Details:

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)

ASHP Residency: _____ Date Started: _____ Date Completed: _____
(Location)

Print Form

CERTIFICATE PROGRAMS

The Certificate Program completed must be a North Carolina Center for Pharmaceutical Care (NCCPC) or American Council on Pharmaceutical Education (ACPE) approved certificate program in the area of practice covered by the CPP agreement. 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:

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Position Held (Date Started) (Date Completed)

Describe clinical experience:

Print Form

PHYSICIAN INFORMATION

****If you will have multiple supervising physicians at the same practice site, please provide the following information for each supervising physician. Also, please have each physician sign and date this form. Attach additional sheets if necessary.**

Physician's Name: _____ NC License Number: _____

Type of Practice: _____

Practice Address: _____

Practice Phone Number: _____ Practice Fax Number: _____

Physician's Name: _____ NC License Number: _____

Type of Practice: _____

Practice Address: _____

Practice Phone Number: _____ Practice Fax Number: _____

Physician's Name: _____ NC License Number: _____

Type of Practice: _____

Practice Address: _____

Practice Phone Number: _____ Practice Fax Number: _____

CLICK "PRINT FORM" (TOP RIGHT CORNER), HAVE THE APPROPRIATE PERSON(S) SIGN & DATE BELOW, AND SUBMIT TO THE NC BOARD OF PHARMACY

Pharmacist Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Approved by:

_____ _____

President of the NC Board of Pharmacy Date:

_____ _____

Executive Director of the NC Board of Pharmacy Date:

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.

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

AUTHORIZATION FOR RELEASE OF MALPRACTICE INSURANCE INFORMATION

To Whom It May Concern:

I, _____ , hereby consent and request that the North Carolina Board of Pharmacy and its employees and/or agents be permitted to examine and obtain copies of 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.

I am willing that a photostat of this Authorization be accepted with the same authority as the original.

Date: _____

_____
Signature

_____
(Print Name)

_____
(Street Address)

_____
(City, State, Zip Code)

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

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. *Have you ever been named as a defendant in a legal action involving professional liability malpractice?

7. *Have you had a professional liability claim paid on your behalf, or paid such a claim on yourself?

8. 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)?

(Questions continue on next page)

CLINICAL PHARMACIST PRACTITIONER APPLICANT BACKGROUND

(Continued)

YES / NO

9. *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?

10. 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.

***If you answer "YES" to question #6, #7, or #9, complete the enclosed form entitled Claims Information. Also, please sign the Authorization to Release Information form if you complete the Claims Information form so we can obtain the detailed information.**

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 registration after proper notice and hearing.

I further state that by filing this application for CPP registration in the State of North Carolina, I hereby authorize and consent to an investigation of my professional reputation and fitness for CPP registration. I agree to provide any additional information which may be requested.

I hereby release, discharge, and exonerate the NC Board of Pharmacy, its agents or representatives and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such information or the investigation made by the NC Board of Pharmacy. 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 or province of Canada.

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.

TEMPLATE FOR CLINICAL PHARMACIST PRACTITIONER PROTOCOLS

Disease State	Drug Product/Therapies	Dosage Form, Schedule, and Tests

*Add additional entries on a separate sheet if necessary. If additional sheets are required, please have the supervising physician initial each page.

Additional Protocols

Doctor of Pharmacy (PharmD) licensed by the North Carolina Board of Pharmacy and approved by the North Carolina Medical Board as a Clinical Pharmacist Practitioner is approved to perform the following functions in collaboration and under the supervision of the following physician(s):

1. Patients with the following disease states will be eligible for referral to the Clinical Pharmacist Practitioner: **[list those disease states described in the chart above].**

2. The Clinical Pharmacist Practitioner will practice as per statute N.C. Gen. Stat. § 90-18.4(b) and regulation 21 NCAC 32T.

3. Emergency Plan **[provide details]**. An example may read as follows:

In the event of a cardiopulmonary arrest, cardiopulmonary resuscitation will be initiated while office staff calls 911. In the event of an emergent event, the office staff will call 911 and the client will be transferred to the emergency department.

4. Consultation and Supervision **[provide details].** An example may read as follows:

In general, the medical director or physician consultation will be sought for all of the following situations as well as any other deemed appropriate. Whenever a physician is consulted, a notation to that effect including the physician's name must be in the patient's chart.

-- When situations arise that go beyond the intent of the protocols or scope of practice, or experience level of the CPP.

-- Whenever a client's condition fails to respond to the management plan in an appropriate time frame.

-- Any uncommon, unfamiliar, or unstable client condition is encountered.

-- Any condition which does not fit the commonly accepted diagnostic pattern for a disease/condition.

-- Whenever a client requests consultation.

-- All emergency situations after initial stabilizing care has been started.

5. Countersignature. The supervising physician will countersign all medical record notes made by the Clinical Pharmacist Practitioner within **seven (7) days** of the date of the visit.

6. Other Protocols/Instructions - **[provide details]**

Approved: _____

Name of Supervising Physician

_____

Clinical Pharmacist Practitioner

Date: _____

North Carolina Board of Pharmacy

Print Form

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.

☐ VISA ☐ MasterCard ☐ DISCOVER

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

☐ AMERICAN EXPRESS

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.