Nuclear Pharmacist Application

Board of Pharmacy
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridaspharmacy.gov
Email: info@floridaspharmacy.gov
Phone: (850) 245-4474
FAX: (850) 921-5389

Florida HEALTH
Medical Quality Assurance

Nuclear Pharmacist Application

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Do Not Write in this Space
For Revenue Receipting Only

All applicants must hold a current Florida Pharmacist license that is active and in good standing.

Nuclear Pharmacist (1020) **$55.00**

Total fee of $55.00 includes the following:	
Application Fee	$55.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. The $55.00 application fee is not refundable.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. LICENSURE HISTORY

A. Do you have a Florida Pharmacist (PS) license that is active and in good standing? ☐ Yes ☐ No

If "Yes," what is the license number? _____

B. Have you ever held a Nuclear Pharmacist (NP) License in Florida? ☐ Yes ☐ No

If "Yes," what was the license number? _____

3. SOCIAL SECURITY DISCLOSURE

This page is exempt from public records disclosure.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Pursuant to Title 42 United States Code § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. For all professions regulated under chapter (ch.) 456, Florida Statutes (F.S.), the collection of Social Security numbers is required by section (s.) 456.013(1)(a), F.S.

Name: _____

4. OTHER ITEMS REQUIRED

☐ A. **Certificate of Training and Experience** (Experiential Training)- All applicants must have certification by their supervising pharmacist of the minimum 500 hours of training and experience as set forth in Rule 64B16-26.303(5), Florida Administrative Code (F.A.C.). All applicants must complete the Certificate of Training and Experience form found at the end of this application.

☐ B. **Proof of Eligibility** (Didactic Training)- All applicants must provide proof of eligibility, which consists of documentation that shows you have completed 200 clock hours of formal didactic training as set for in Rule 64B16-26.303(3), F.A.C. Acceptable forms of proof are a letter on university letterhead or a certificate of completion from the university indicating the completion of these hours.

Rule 64B16-26.303(6), F.A.C., provides that "if the didactic and experiential training required in this section has not been completed within the last seven years, you must have engaged in the lawful practice of nuclear pharmacy in another jurisdiction for at least 1,080 hours during the last seven years."

Documentation must be sent to the board office at info@floridaspharmacy.gov, or mailed to:

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

5. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, F.S.

I am aware that my nuclear pharmacist license may be suspended or revoked if I violate any provision of Chapter 456, Chapter 465, and/or any laws or rules adopted pursuant thereto.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print out this application and sign it or sign it digitally. MM/DD/YYYY

Complete forms must be sent directly by the supervisor to the board office at info@floridaspharmacy.gov, or mailed to:

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Board *of* Pharmacy
Certificate of Training and Experience

Part I: Applicant Information (To be completed by applicant)

Applicant Name: _____
Last First Middle

Street Address: _____

City: _____ State: _____ ZIP: _____

Home/Cell Phone: _____ Work Phone: _____
Input without dashes

Part II: Supervisor Information (To be completed by the supervising Nuclear Pharmacist)

Supervisor Name: _____
Last First Middle

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Home/Cell Phone: _____ Work Phone: _____

Pharmacist License #: _____ Nuclear Pharmacist License #: _____

Part III: Certification of Assessment and Evaluation (To be completed by the supervisor)

I certify that the applicant above completed either a minimum of 500 hours of training and experience in the handling of unsealed radioactive material within the last seven years, or 1,080 hours engaged in the lawful practice of nuclear pharmacy in another jurisdiction within the last seven years.

This training and experience or lawful practice occurred under my supervision from _____ to _____.
MM/DD/YYYY MM/DD/YYYY

If I am certifying 500 hours of training and experience, I further certify the training included the following as mandated by Rule 64B16-26.303, F.A.C.

1. Ordering, receiving, and unpackaging in a safe manner, radioactive material, including the performance of related radioactive surveys;
2. Calibrating dose calibrators, scintillation detectors, and radiation monitoring equipment;
3. Calculating, preparing, and verifying patient doses, including the proper use of radiation shields;
4. Following appropriate internal control procedures to prevent mislabeling;
5. Learning emergency procedures to safely handle and contain spilled materials, including related decontamination procedures and surveys;
6. Eluting technetium-99m from generator systems, assaying the eluate for technetium-99m, and technetium-99m labeled radiopharmaceuticals; and
7. Clinical practice concepts.

Supervisor Signature_____ Date: _____
MM/DD/YYYY