DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

IMMUNIZATION ADMINISTRATION CERTIFICATION APPLICATION AND INFORMATION

August 2015

DH MQA 1125, 08/2015
Rule 64B16-26.1032, F.A.C

Dear Florida Immunization Administration Certification Applicant:

Thank you for applying for certification to administer immunizations in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the board) staff to process your application as soon as possible.

Florida Statutes require a completed application and fees before your application can be reviewed. You should use the enclosed checklist to ensure that all sections of the application are complete and that the required forms are submitted. Please read these instructions carefully and fully before submitting the application. You should keep a copy of the completed application and all other materials sent to the board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 7-14 days if any materials are incomplete.

If you need to communicate with the board staff, you are encouraged to email the board staff at info@floridaspharmacy.gov or you may at call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Florida Board of Pharmacy

General Information

Requirements for Pharmacist Immunization Administration Certification:

To become certified to administer immunizations and epinephrine, a pharmacist must meet the following requirements.

1) Must hold a Florida pharmacist license that is active and in good standing.

2) Must successfully complete an immunization administration certification program of no fewer than 20 hours, approved by the Florida Board of Pharmacy.

3) Must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of immunizations by the pharmacist. The written protocol shall include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer immunizations and epinepherine. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for immunization. Supervising physicians shall review the administration of immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician.

4) Must maintain at least $200,000 of professional liability insurance.

5) Must obtain written permission from the pharmacy owner, if the applicant is to administer immunizations while acting as an employee of a pharmacy.

6) Once certified, must report immunizations administered to the state registry of immunization information, Florida SHOTS. If a pharmacist is planning to administer immunizations outside a pharmacy practice setting, the pharmacist must register with Florida SHOTS as an individual. If a pharmacist is administering immunizations as an employee of a pharmacy, the pharmacy practice location (permittee) must designate one pharmacist certified to administer immunizations to register and be responsible for maintenance of the pharmacy's Florida SHOTS account. Please check with your pharmacy's Prescription Department Manager to determine who will submit this information for your pharmacy. A Florida SHOTS application is attached for your convenience.

   For information on how to batch upload this data, please visit the Florida SHOTS website at http://www.flshots.com/resources/links.html

Requirements for Registered Pharmacy Intern Immunization Administration Certification:

To become certified to administer immunizations, a registered pharmacy intern must meet the following requirements.

1) Must hold a pharmacy intern registration that is active and in good standing.

2) Must successfully complete an immunization administration certification program of no fewer than 20 hours, approved by the Florida Board of Pharmacy.

3) Must be directly supervised by a licensed pharmacist whose license is clear and active and who is also certified to administer vaccines. The supervision must be on a ratio of one pharmacist to one intern.

Please be advised the Immunization Administration Certification will be added to your Registered Pharmacy Intern license and will not automatically transfer over to your Pharmacist license.

You will be required to submit a new Immunization Administration Certification application, fee, and all required supporting documentation in order to administer vaccines as a licensed pharmacist.

Application Processing

Please read all application instructions before completing your application.

Within 7-14 days of receipt of your application and fees, the board office will notify you of the receipt of your application, any required documents, and your status. If your application is complete, you will be issued the certification within 7-14 days. If your application is incomplete, you will be notified in writing of the missing documents required to complete your application.

APPLICATION REQUIREMENTS FOR IMMUNIZATION ADMINISTRATION CERTIFICATION

Please submit the following to the Florida Board of Pharmacy:
P.O. Box 6320, Tallahassee, FL 32314-6320

ITEM #1 – Immunization Administration Certification Application: All sections must be completed in full. Failure to submit a complete application will result in a processing delay. If you provide false information, the board *may* deny your application for certification. **Please attach a check payable to THE FLORIDA DEPARTMENT OF HEALTH in the amount of $55.00. *No fee is required for Pharmacy Interns.**

Immunization Administration Certification Program: Pharmacists and Registered Pharmacy Interns must successfully complete an immunization administration certification program of no fewer than 20 hours, approved by the Florida Board of Pharmacy Continuing Education Committee. **Please attach a copy of your certificate of completion to your application. A copy of your CPR card must be submitted with the application if your 20 hour Immunization Certification Program Certificate indicates that it must be accompanied by written proof of training.**

Protocol: Pharmacists must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of immunizations by the pharmacist. The written protocol shall include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer immunizations. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for immunization. Supervising physicians shall review the administration of immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician.

A pharmacist may not enter into a protocol that is to be performed while acting as employee without the written approval of the owner of the pharmacy.

Professional Liability Insurance: Upon becoming certified, pharmacists must maintain at least $200,000 of professional liability insurance. **Please attach a copy of your professional liability insurance policy to your application. (NOTE: If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company letterhead verifying that you are covered under their company policy.)**

Florida SHOTS Registration

Pharmacists certified to administer immunizations are responsible for reporting electronic immunization data to Florida SHOTS, as required by *Florida Statutes*.

Each practice location (pharmacy permittee) where immunizations will be administered must designate one person to register with the Florida SHOTS program as described below. Please contact your Prescription Department Manager to determine who will submit data to the immunization registry for your pharmacy.

The registered pharmacist is responsible for reporting data to the immunization registry as required by statute, and must ensure staff adherence to confidentiality and information security, management of system accounts (including immediate termination of accounts for staff no longer employed), and maintenance of new user identification and temporary password assignment.

Pharmacists who administer immunizations outside the pharmacy practice setting must register with Florida SHOTS as an individual.

Please follow the directions below to register for access to Florida SHOTS.

1. Obtain a DH 1997 Form (*Authorized Licensed Pharmacist User Agreement for Access to Florida SHOTS (Florida State Health Online Tracking System*)) from www.flshots.com.
2. Complete the form and mail or fax to the address indicated on the form. Be sure to include the pharmacy permit number as well as the applicant's pharmacist license number. Also, be sure to provide the requested information regarding the immunization administration certification program.
3. Once the application form is received by the Florida SHOTS enrollment staff, a valid license check is conducted to ensure credentials are in place and in good standing.
4. Florida SHOTS enrollment desk staff will contact you with information about access to Web-based training for Florida SHOTS users.
5. Once web-based training for Florida SHOTS users is complete, an organization account is established for the permitted pharmacy and the pharmacist applicant is provided with a user ID and temporary password.
6. The authorized pharmacist applicant may add others to the organization account using their enrollment credentials. Adding others is subject to pharmacy policies regarding background checks and access to confidential data.
7. Accounts must be maintained by the registered pharmacist for each practice location (permit). When authorized users terminate from an organization, their access to Florida SHOTS must be terminated by the registered pharmacist immediately. Florida SHOTS includes an automated password reset that allows authorized users to maintain passwords.
8. Call the Florida SHOTS Enrollment Desk at 1(877) 888-SHOT (7468) with any questions regarding the status of your enrollment or account.

For information on how to batch upload this data, please visit the Florida SHOTS website at http://www.flshots.com/resources/data.html.

APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation to the board, will result in an incomplete application. **Final approval cannot be granted until the application is complete**. Faxed applications will not be accepted.

_____**Immunization Administration Certification Application (Item #1)**

_____**Immunization Certification Program –** All pharmacists must complete an immunization administration certification course prior to board certification. The course shall be no less than twenty (20) contact hours, shall be board approved, and shall cover the subjects listed in subsection 64B16- 26.1031, F.A.C. Please refer to CE Broker's website at www.CEBroker.com for a list of approved providers. **(Submit a copy of the course completion certificate to the Board of Pharmacy.)**

_____**Copy of CPR Card-** A copy of your CPR card must be submitted with the application if your 20 hour Immunization Certification Program Certificate indicates that it must be accompanied by the card.

The remaining requirements apply to pharmacists only.

____ Check made payable to the FLORIDA DEPARTMENT OF HEALTH in the amount of $55.00. *** No fee is required for Pharmacy Interns**.

_____**Protocol**– All pharmacists must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of immunizations by the pharmacist. The written protocol shall include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer immunizations. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for immunization. Supervising physicians shall review the administration of immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician. **(Submit a copy of the protocol between the applicant and practitioner.)**

_____**Professional Liability Insurance** – All pharmacists must maintain at least $200,000 of professional liability insurance. **(Submit a copy of the professional liability insurance policy to the Board of Pharmacy. NOTE: If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company letterhead verifying that you are covered under their company policy.)**

FLORIDA BOARD OF PHARMACY
P.O. Box 6320 • Tallahassee, FL 32314-6320
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www.floridaspharmacy.gov

ITEM #1 – IMMUNIZATION ADMINISTRATION CERTIFICATION APPLICATION (3015)

Application Type:____Pharmacist *Fee: $55.00 (2201) ____Pharmacy Intern (2202) * No Fee Required

1. Biographical Data

Last Name	First Name	Middle Name

Mailing Address	City	State	Zip

Home Phone Number	Business Phone Number	E-Mail Address

2. Equal Opportunity Data – We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43FR38295 (August 25, 1978). The information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

SEX: 0 Male 0 Female
RACE: 0 Caucasian 0 Black 0Hispanic 0 Asian 0 Native American 0 Other

3. Do you have a Florida Pharmacist (PS) license or a Pharmacy Intern (PSI) registration active and in good standing? If yes, what is the license or registration number? **If an Intern license number is listed in this section the Immunization Certification will be added to the Intern license and will not automatically transfer to a pharmacist license.**

Yes_____ No_____ Florida License Number: PS_____**or** PSI_____

4. Have you ever held an immunization administration certification in Florida? If yes, what was the certification number?

Yes_____ No_____ Florida Certification Number: _____

5. Immunization Administration Certification Program - Have you successfully completed a Florida Board of Pharmacy approved immunization administration certification program? If yes, please provide the provider name, provider number, date of completion, and certificate number. Please attach a copy of the certificate of completion to this application.

Yes_____ No _____

Provider Name	Provider Number	Date of Completion	Certificate Number

6. Protocol Information (pharmacists only) – Please provide the name, license number, address, and contact telephone number of the physician licensed under chapter 458 or 459, *Florida Statutes*, with whom you have entered into a protocol. Please attach a copy of the protocol to this application.

Physician Name	Physician License Number	Contact Telephone Number

Mailing Address

City	State	Zip Code

7. Do you intend to administer immunizations while acting as the employee of a pharmacy?

Yes_____ No _____

8. Please provide the following information for the pharmacy where you are employed and intend to administer immunizations.

Pharmacy Name	Pharmacy Permit Number	Pharmacy Telephone Number	
Street Address	**City**	**State**	**Zip Code**
Prescription Department Manager Name	**License Number**	**Contact Telephone Number**	

9. Are you the designated Florida SHOTS registrant for your pharmacy or do you plan to administer immunizations outside a pharmacy practice location?

Yes_____ No _____

If yes, please complete the enclosed Florida SHOTS user agreement and submit it to the Department of Health Bureau of Immunization at the address provided on the form and skip question 10. If no, please answer question 10.

10. If you are not the designated Florida SHOTS registrant, please provide the designated registrant's information below. (NOTE: If your corporate office uploads this data, please write "Headquarters" under "pharmacist name." You do not need to provide this if you are a pharmacy intern.)

Pharmacist Name	License Number	Contact Telephone Number

11. Professional Practice Insurance (pharmacists only)– Do you maintain at least $200,000 of professional liability insurance?
If yes, please provide your insurance provider name, policy number, and policy expiration date. Please attach a copy of the policy to this application. **(NOTE: If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company**

Yes_____ No _____

Insurance Provider Name	Policy Number	Policy Expiration Date

The information contained herein is true and correct to the best of my knowledge, and am aware that my immunization administration certification may be suspended or revoked if I violate any pharmacy law, rule or regulation, and the Florida Board of Pharmacy Code of Conduct, and hereby affix my signature as acknowledgement and agreement of such terms.

_____ _____
Applicant Signature Date