

Pennsylvania State Board of Pharmacy  
P.O. Box 2649  
Harrisburg, PA 17105-2649  
(717) 783-7156  
[www.dos.state.pa.us/pharm](http://www.dos.state.pa.us/pharm)

**APPLICATION FOR AUTHORIZATION TO ADMINISTER INJECTABLE MEDICATIONS,  
BIOLOGICALS AND IMMUNIZATIONS** (#854 111, Rev. 12/11)

Attach a \$30.00 check or money order made payable to the "Commonwealth of PA." Fees are not refundable.  
Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment. If your original application is more than a year old and the authorization has not been issued to you, the Board may require you to submit an entirely new application and the application fee.

Name: \_\_\_\_\_,  
Last First Middle

Home address: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Pharmacist license number\*: \_\_\_\_\_ Exp. date of pharmacist license: \_\_\_\_\_

\*If your pharmacist license is pending, please provide your social security no.: \_\_\_\_\_

**STATEMENT**

I verify that I hold and will maintain a current basic cardiopulmonary resuscitation (CPR) certificate issued by the American Heart Association, American Red Cross or a similar health authority or professional body approved by the Board. **A photocopy of my current CPR card (front, back and any necessary legend) is attached.**

I verify that the statements in this application are true and correct to the best of my knowledge, information, and belief. I understand that false statements are made subject to the penalties of 18 PA C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. Section 4911.

\_\_\_\_\_  
**Pharmacist Signature**

\_\_\_\_\_  
**Date**

Have you:

1. Fully completed page one of the application and attached the proper fee?
2. Attached a photocopy of your current CPR card, including the front, back and any necessary legend?  
Note: A list of approved CPR providers/programs is posted at [www.dos.state.pa.us/pharm](http://www.dos.state.pa.us/pharm).
3. Completed the top of page two?
4. Made arrangements to have the education/training provider complete the "Certification of Education and Training" section of page two? Please note that the **education/training provider must directly submit** page two to the Board of Pharmacy office.

Instructions to the Pharmacist:

- 1. Please provide your name and pharmacist license number here.

Name: \_\_\_\_\_

Pharmacist license number\*: \_\_\_\_\_

\*If your license is pending, please provide your social security no.: \_\_\_\_\_

- 2. Submit page two to your education/training provider for completion. **Your education/training provider** must submit page two **directly** to the Board of Pharmacy at PO Box 2649, Harrisburg, PA 17105-2649.

### CERTIFICATION OF EDUCATION AND TRAINING

As the authorized representative of \_\_\_\_\_,  
Name of Education and Training Provider

I verify that this program provider/educational institution is accredited by the Accreditation Council for Pharmacy Education and that the above-noted individual has satisfactorily completed an academic and practical curriculum related to the administration of injectable medications, biologicals, and immunizations that meets the requirements under Board Regulation Section 27.407.

The course was completed by the above-noted individual on \_\_\_\_\_.  
Date

I verify that the statements in this application are true and correct to the best of my knowledge, information, and belief. I understand that false statements are made subject to the penalties of 18 PA C.S. Section 4904 relating to unsworn falsification to authorities.

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. Section 4911.

\_\_\_\_\_  
Signature of Representative Date

\_\_\_\_\_  
Printed Name of Representative

Place official  
organizational seal  
or stamp here.

\_\_\_\_\_  
Street Address of Education/Training Provider

\_\_\_\_\_  
City, State and Zip Code of Education/Training Provider

**\*\*\*\*IMPORTANT INFORMATION FOR THE EDUCATION/TRAINING PROVIDER\*\*\*\***

The Board of Pharmacy requires direct source verification of education. All documents must be submitted by the education/training provider in an envelope containing the **preprinted return address of the provider**. If a provider is unable to meet this requirement, each educational document must be notarized prior to submission.