APPLICATION FOR CERTIFICATE OF AUTHORITY TO ADMINISTER IMMUNIZATIONS AND/OR OTHER INJECTABLE MEDICATIONS

North Dakota State Board of Pharmacy
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FEE: {waived}

NAME: _____

ADDRESS: _____

City State Zip

ND PHARMACIST LICENSE: _____

IMMUNIZATION/INJECTION ADMINISTRATION COURSE SUCCESSFULLY COMPLETED:

_____

_____

DATE OF COMPLETION: _____

ATTACH COPY OF CERTIFICATE OF COMPLETION IMMUNIZATION/INJECTION ADMINISTRATION COURSE

ATTACH COPY OF CERTIFICATION IN CARDIOPULMONARY RESUSCITATION (CPR) _____
Expiration Date

OR

COPY OF CERTIFICATION IN BASIC CARDIAC LIFE SUPPORT (BCLS) _____
Expiration Date

Signature: _____ Date: _____

IS THIS IS A RENEWAL: YES NO
LIST OR INCLUDE COPIES OF 6 HOURS OF CONTINUING EDUCATION WHICH IS DEDICATED TO IMMUNIZATIONS/ INJECTIONS

Please give a brief statement of your activities in this area over the past two years: