

**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 PHARMACY INTERN 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: \_\_\_\_\_