MAILING ADDRESS:
Missouri Board of Pharmacy
P.O. Box 625
Jefferson City, MO 65102
(573) 751-0091
(573) 526-3464 (FAX)

DELIVERY ADDRESS:
3605 Missouri Boulevard
Jefferson City, MO 65109

PHARMACIST NOTIFICATION OF INTENT TO ADMINISTER VACCINES BY PROTOCOL

PHARMACIST NAME			LICENSE NO.	
HOME ADDRESS	STREET	CITY	STATE	ZIP CODE
	HOME PHONE NO.		COUNTY	
EMAIL ADDRESS				

VACCINES THAT WILL BE ADMINISTERED

☐ Influenza ☐ Shingles ☐ Pneumonia ☐ Meningitis

☐ **AMENDED NOTIFICATION:** CHECK BOX IF YOU ARE AMENDING A CURRENTLY EFFECTIVE NOTIFICATION OF INTENT IN ORDER TO ADD VACCINES TO BE ADMINISTERED AS AUTHORIZED BY CHAPTER 338, RSMO.

PHARMACIST STATEMENT

1. I hold a current, unrestricted Missouri license to practice pharmacy that is not on probation.
2. I hold a current cardiopulmonary resuscitation (CPR) certification issued by the American Heart Association or the American Red Cross. **Certification Expiration Date**: _____
   (NOTE: We need the Expiration Date, not Issue Date. Failure to include correct date, will result in rejection of this form and inability to administer.)
3. I have successfully completed a certificate program in the administration of vaccines accredited by the Accreditation Council for Pharmacy Education (ACPE).

   Name of Program:_____ Date of Completion: _____
4. I have completed a minimum of two hours (0.2 CEU) of continuing education per calendar year related to administration of vaccines.
5. I have provided documentation of items 1-4 to the physician authorizing my protocol.
6. I have a signed and dated, written protocol with a physician to administer the above-listed vaccines, and I maintain a copy of that protocol.

By signing this form, I hereby attest that I have complied with each of the above statements, and state that I maintain copies of the certifications required in #2 and #3 above.

DO <u>NOT</u> SUBMIT COPIES OF YOUR CERTIFICATES OR CONTINUING EDUCATION WITH THIS FORM.

PHARMACIST SIGNATURE DATE