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 VIRAL INFLUENZA VACCINATIONS

PHARMACIST NAME			LICENSE NO.	
HOME ADDRESS	STREET	CITY	STATE	ZIP CODE
	HOME PHONE NO.		COUNTY	
AFFILIATED PHARMACY NAME			PHARMACY PERMIT NO.	
PHARMACY ADDRESS	STREET	CITY	STATE	ZIP CODE
	PHARMACY PHONE NO.		COUNTY	
DRUGS THAT WILL BE ADMINISTERED				

PHARMACIST STATEMENT

1. I hold a current, unrestricted Missouri license to practice pharmacy.
2. I hold a current provider level cardiopulmonary resuscitation (CPR) certification issued by the American Heart Association or the American Red Cross or equivalent. Certification Expiration Date: ____
3. I have successfully completed a certificate program in the administration of viral influenza vaccinations accredited by the Centers for Disease Control, the Accreditation Council for Pharmacy Education (ACPE) or a similar health authority or professional body approved by the Missouri Board of Pharmacy.

   Name of Program:____ Date of Completion: ______________________
4. I have completed a minimum of two hours (0.2 CEU) of continuing education per year related to administration of viral influenza vaccinations.
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 drugs, 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.

PHARMACIST SIGNATURE	DATE