CONTINUING PHARMACY EDUCATION PROVIDER FOR PHARMACY JURISPRUDENCE PROGRAMS
and
PROVIDER OF CONTINUING EDUCATION CREDIT FOR VOLUNTEER PHARMACY SERVICES APPLICATION

UPDATED 4/29/2021

Introduction

The primary goal of this application process is to ensure that Ohio pharmacists and pharmacy technicians are provided with quality continuing pharmacy education.

Providers should keep in mind that although the Board will be evaluating past performance, the primary purpose of the questionnaire is to seek assurance that the provider is willing and able to meet the criteria for in-state providers of pharmacy jurisprudence or volunteer pharmacy services. The requested information is needed so that the Board will have enough data available to determine if a provider should be approved. The questions also serve to assist the provider in assessing its own strengths and weaknesses and areas in need of improvement.

Instructions

- Please complete all responses and maintain a copy of the application submitted in your files.
- The amount of space for responses on the application is not intended to dictate the length of the responses. Please use additional pages for responses requiring additional space. Please identify the question to which such responses refer.
- Please return the attached application, supplemental forms, and any additional forms used to the Board office via email to CEProvider@pharmacy.ohio.gov. Direct any questions you have to the Board's Continuing Pharmacy Education Coordinator by calling 614/466-4143 or email at CEProvider@pharmacy.ohio.gov.

Once approved as an in-state provider of continuing education, the provider shall maintain or update the provider's contact information, at a minimum, biennially, in accordance with a schedule adopted by the Board. Contact information shall be updated using this online form approved by the Board. It is the provider's responsibility to keep all contact information current.

For more information, on in-state continuing education providers please review Chapter 4729-6 of the Ohio Administrative Code.

Application

Part I – Provider Information

Name of organization, individual, institution, association, corporation, or agency that is applying for approval as a provider of continuing pharmacy education or provider of volunteer pharmacy services:		
Street Address	**City, State**	**Zip**
Select the type of program (select only one): ◯ **Pharmacy Jurisprudence (Law)** ◯ **Volunteer Services**		
If a provider of volunteer services, provide Board of Pharmacy TDDD Licensing No (If applicable)		

Part II – Program Director or Volunteer Coordinator Information

First Name	**Last Name**
Job Title	**Contact Phone Number (XXX-XXX-XXXX)**
Ohio Pharmacist License Number (for Jurisprudence Providers ONLY)	**Email Address**
If this individual has served in this capacity for less than one year, please indicate predecessor name [write N/A if not applicable]:	**If this individual has served in this capacity for less than one year, please indicate predecessor's length of service (MM/YY – MM-YY), [write N/A if not applicable]:**
If the person in charge is elected or appointed, as with local professional associations, will this person change from year to year? **Yes** ☐ **No** ☐ **(Please check one)** **NOTE: If yes, it is the responsibility of the organization to notify the Board as soon as a new person is elected or appointed. This must be done by having the individual complete a new "Form A" (included in this application) and immediately submitting information to the Board using the instructions on the first page of this document.**	

What group or organization have you worked with in the past year in providing continuing pharmacy education?

Part III – Administrative Requirements

Describe how programming is or will be promoted:
What system will be used for the maintenance and availability of records of participation in continuing pharmacy education/volunteer activities and where will they be stored?

IMPORTANT: ***An applicant must attach a sample certificate, letter, or other document that will be used as evidence to participants of satisfactory completion of a continuing pharmacy education activity. Indicate the way this document is distributed to participants. Certificate must include name of provider, title of event, program number, date of event, number of hours (CEUs) awarded, name of participant, and signature of CE provider.***

Part IV – Educational Content Development (skip this section if applying for volunteer services)

Describe the goals of your continuing pharmacy education effort.
State the goals and educational objectives of your most recently offered activity, or upcoming activity.
Describe the steps taken in the planning process for a continuing pharmacy education experience.

Describe the way topics for continuing pharmacy education experiences are determined. Indicate how continuing education participants are involved in planning future programs.
Describe the review process that an on-going program might undergo before it is offered to a new audience.

Part V - Methods of Delivery (skip this section if applying for volunteer services)

Indicate the number of continuing pharmacy education experiences delivered or sponsored in the past 12 months (from date of application) by each of the methods listed below:

_____ Live Lecture	**_____Journal Article with Evaluation Techniques**
_____ Workshop/Discussion Group	**_____Home Study Book or Booklet**
_____ Film/Videotape	**_____Webinar**

_____ Other (explain): _____

IMPORTANT: ***Please complete "Form B" (included in at the end of this application) for programs offered in the past 12 months.***

Part VI - Evaluation (skip this section if applying for volunteer services)

What opportunities will be given for the participants to assess his/her achievement of personal objectives? Please attach a sample of a typical evaluation instrument.
How will you evaluate the effectiveness of the continuing pharmacy education experiences and the level of fulfillment of the stated objectives?

Part VII - Additional Information (skip this section if applying for volunteer services)

Indicate in the box below (or as an attachment) any information which will help evaluate your ability as a provider to comply with the criteria for either:

- Rule 4729-6-02 | Criteria for in-state approved providers of pharmacy jurisprudence continuing education.
- Rule 4729-6-03 | Criteria for in-state approved providers of continuing pharmacy education for providing volunteer health care services.

Part VIII - Attestation of Program Director or Volunteer Coordinator

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. AND 4729. OF THE OHIO REVISED CODE THAT THE ANSWERS PROVIDED ON THIS FORM AND IN THE ONLINE APPLICATION SUBMITTED TO THE STATE BOARD OF PHARMACY ARE **TRUE, CORRECT, AND COMPLETE.**	
Signature of Program Director / Volunteer Coordinator	**Date Signed**
Print Name	

"FORM A"

CONTINUING PHARMACY EDUCATION ADMINISTRATIVE PERSONNEL

PROVIDER (name of organization/institution)

NAME:	DATE OF APPLICATION:

PERSON IN CHARGE (CE or Volunteer Coordinator)

NAME AND TITLE:	DATE OF BIRTH:
STREET ADDRESS:	DATE APPOINTED:
CITY, STATE, ZIP CODE:	PROVIDER NUMBER: (for re-evaluation only)
E-MAIL ADDRESS:	OHIO PHARMACIST LICENSE NUMBER (pharmacist license not required for volunteer services)

EMPLOYMENT (List most recent first)

EMPLOYER:	FROM: (Month/Year)	TO: (Month/Year)
DESCRIPTION:	TITLE:	
EMPLOYER:	FROM: (Month/Year)	TO: (Month/Year)
DESCRIPTION:	TITLE:	

EDUCATION (skip this section if applying for volunteer services)

COLLEGE NAME-Undergraduate:	FROM-TO:	DEGREE:	MAJOR:
COLLEGE NAME-Graduate:	FROM-TO:	DEGREE:	MAJOR:
COLLEGE NAME-Graduate:	FROM-TO:	DEGREE:	MAJOR:

COLLEGE NAME-Honorary Degree:	DEGREE:	DATE:

LICENSED AS A PHARMACIST (skip this section if applying for volunteer services)

DATE:	LICENSE NO.:	STATE:	DATE:	LICENSE NO.:	STATE:
DATE:	LICENSE NO.:	STATE:	DATE:	LICENSE NO.:	STATE:

PROFESSIONAL SOCIETY MEMBERSHIPS (skip this section if applying for volunteer services)

OTHER ACCOMPLISHMENTS (Publications, awards, etc.) (skip this section if applying for volunteer services)

QUALIFICATIONS FOR APPOINTMENT

"FORM B"

LIST OF PROGRAMS OFFERED IN THE PAST 12 MONTHS

PROVIDER NAME: _____

Title of Program	Date Offered	Number of Participants	Contact Time	Amount of C.E. Credit	Name(s) of author, speaker, or others presenting program	Method of Delivery*

*Lecture, webinar, workshop, home-study, journal article, etc. (PLEASE DUPLICATE THIS FORM AS NEEDED)