

Section II: Pharmacy Residency Program Certification

INSTRUCTIONS: As a pharmacist residency program director you must:

1. Complete this Section, read, sign and date the certification below, and have your signature notarized by a Notary Public.
2. Send both pages of the completed form to the address at the end of this page.

Name of resident: _____
(See Section I, item 3)

Name of residency program: _____

Date entered residency program: _____ / _____ / _____
mo. day yr.

Date completed the required competencies: _____ / _____ / _____
mo. day yr.

I am the residency program director and I hereby certify that:

1. The statements made on this form regarding this applicant's pharmacy practice residency experience are true, complete and correct; and
2. the applicant has successfully achieved each of the following competencies as part of a residency program in pharmacy practice approved by the Department:
 - a. sterile product preparation and technique;
 - b. non-sterile compounding preparation and technique;
 - c. performing dosing calculations, including but not limited to aliquot, proportions, and infusion drip-rates;
 - d. medication safety procedures, including, but not limited to, identifying potential look-alike and sound-alike drugs and other medication error prevention techniques;
 - e. drug distribution, including but not limited to preparing, dispensing and verifying the accuracy of filled prescriptions or medication orders; and
 - f. such other competencies in pharmacy practice as may be required by the department; and
3. the assessment of these competencies was made in an objective fashion, the methods of which will be shared with the Department upon request.

The undersigned affirms under penalty of perjury that the answers and statements that he/she has made in the above application are true and have been made and given with the intent of having the New York State Education Department and the New York State Board of Pharmacy rely on the truth thereof.

Signature of Residency Program Director: _____ Date: _____ / _____ / _____
mo. day yr.

Print name: _____

License number: _____ State in which you are licensed: _____

Institution name: _____

Address: _____

City: _____ State: _____ Zip code _____

Telephone: _____ Fax: _____ Email: _____

Notary

State of _____ County of _____ On
the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the certification.

Notary Public signature _____

Notary ID number _____

Notary Stamp

Expiration date _____ / _____ / _____
Month Day Year

Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, Pharmacy Unit, 89 Washington Avenue, Albany, NY 12234-1000.