

Nuclear Pharmacist Application

Name: _____

Address: _____

Phone: _____ Fax: _____ E-mail: _____

License Number: _____

Check One:

- I am certified as a Nuclear Pharmacist by the Board of Pharmaceutical Specialties of the American Pharmaceutical Association.

Date: _____ Certification Number: _____

Note: You must attach a copy of your certification.

- I have completed a **minimum** of **200** contact hours of didactic instruction in an accredited school or college of pharmacy, and a **minimum** of **500** hours of clinical nuclear pharmacy training under the supervision of a Board of Pharmaceutical Certified Nuclear pharmacist.

Note: You must attach evidence of your instruction and training.

Present Employer

Name: _____

Address: _____

Phone: _____ E-mail: _____

Affirmation

I declare and affirm that the statements made in this application, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, my application may be cause for denial or loss of licensure and may result in criminal prosecution.

Applicant Signature: _____

Date: _____

Mail the completed form along with any required documentation to: The New York State Education Department, Office of the Professions, State Board of Pharmacy, 89 Washington Avenue, Albany, New York, 12234-1000