

Pharmacist Immunization Certification Form

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Department Use Only

Application for Certification

Applicants Must Complete All Pages Of This Application *In Ink*

Complete the entire form and submit it with the \$100 fee for certification and any other required documentation directly to the Office of the Professions at the address at the end of this form. Your signature on this form must be notarized by a Notary Public.

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|-------|----|-----|
| \$100 | 20 | I P |
|-------|----|-----|

1 Social Security Number _____
(Leave this blank if you do not have a U.S. Social Security Number)

Date Certified

2 Birth Date Month _____ Day _____ Year _____

Initials

3 Print Name Exactly As It Appears On Your License

Last _____
First _____
Middle _____

5 Telephone/E-Mail Address

Daytime phone

Area Code _____ Phone _____

E-mail Address (please print clearly)

4 Mailing Address (You must notify the Department promptly of any address or name changes.)

Line 1 _____
Line 2 _____
Line 3 _____
City _____
State _____ Zip Code _____
Country/Province _____

6 New York State pharmacist license number: _____ Registration expiration date: _____ / _____ / _____
mo. day yr.

Or, if you recently graduated from an ACPE accredited program

College of Pharmacy: _____ Date of graduation: _____ / _____ / _____
mo. day yr.

7 I have attached a copy of an approved course completion certificate in immunization. Yes No

If you are a recent graduate of a NYS ACPE accredited program and you completed the immunization program as part of the college curriculum, please provide the following:

Name of college attended: _____

Date(s) of program: _____

I have attached a copy of a current valid course completion card in Basic Life Support (BLS/CPR) or its equivalent. Yes No

I have been actively administering immunizations in other state(s). Yes* No
*If **yes**, submit documentation (a signed letter with name of state, time period, and that you have been administering immunizations is sufficient).

8 Affidavit With Acknowledgment (Notarization required.)

Applicant

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.

Signature of the applicant: _____

Date _____ / _____ / _____
Month Day Year

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 application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Expiration date _____ / _____ / _____
Month Day Year

Notary Stamp

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, PO Box 22063, Albany, NY 12201. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.