

Temporarily-Licensed Pharmacy Technician (TLPT) Form

As a temporary license, a temporarily-licensed pharmacy technician may be employed solely for the purpose of administering COVID-19 vaccines under the direct supervision of a licensed and currently registered pharmacist.

Instructions

1. Complete Section I and sign and date item 13.
2. Submit this form to the Supervising Pharmacist (Pharmacist in Charge) of the location you are to be employed at to complete Section II. You **MUST** provide a copy of any required documentation/certificate to the supervising pharmacist. You cannot practice as a temporarily-licensed pharmacy technician until the supervising pharmacist completes Section II of this form.
3. If you are employed at a different location and/or under a different supervising pharmacist, **YOU MUST** complete a **NEW** Temporarily-Licensed Pharmacy Technician Form with the new supervising pharmacist.

Section I: Temporarily-Licensed Pharmacy Technician Information

1. Print Name
Last _____
First _____
Middle _____
4. Home Telephone/Email Address
Daytime Phone _____
Area Code _____ Phone _____
Email Address (please print clearly) _____
2. Birth Date Month Day Year

3. Home Mailing Address
Line 1 _____
Line 2 _____
Line 3 _____
City _____
State ZIP Code _____
5. Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? Yes No
6. Are criminal charges pending against you in any court? Yes No
7. Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you? Yes No
8. Are charges pending against you in any jurisdiction for any sort of professional misconduct? Yes No

NOTE: If you answer "Yes" to any questions numbered 5-8, submit a letter giving a complete detailed explanation to your supervising pharmacist. Include copies of any court records including a Certificate of Disposition. If there are offenses in multiple courts, please provide the same for each action to the supervising pharmacist of the location you are to be employed at. In answering these questions, consider whether, pursuant to Executive Law § 296(16), you are required to report any arrests, criminal accusations, or dispositions of such arrests or criminal accusations. If the court can no longer provide documentation, you must request, from the court, a letter stating why they cannot provide the documents.

9. Organization that certified you as a pharmacy technician:

Certificate Number _____ Date of certification mo. day yr.

10. Organization that certified you in cardiopulmonary resuscitation (CPR):

Certificate of Completion Number _____ Date of certification mo. day yr.

11. Check each to indicate that you:

have completed a hands on immunization training course of six hours or greater duration approved by ACPE.

Date of certification _____
mo. day yr.

have completed New York State COVID-19 Vaccine Training for Vaccinators Training Module(s) which includes infection control and PPE procedures.

Date of certification _____
mo. day yr.

12. If you have previously been employed as a temporarily-licensed pharmacy technician in New York State, you **must** list your previous supervising pharmacists (pharmacists in charge) (attach additional sheets if necessary).

Supervising Pharmacist _____

Supervising Pharmacist License Number _____ Dates worked, from _____ to _____
mo. day yr. mo. day yr.

Pharmacy establishment where employment took place _____

Pharmacy establishment address _____ Pharmacy Registration Number _____

13. I request and give my permission to the supervising pharmacist named to complete Section II of this form, and to release any other information requested by the New York State Education Department and Department of Health in connection with my practice as a temporarily-licensed pharmacy technician. I also declare and affirm that the statements made on this form, including accompanying documents, are true, complete and correct. I understand that any false or misleading information in, or in connection with, information on this form may result in criminal prosecution.

Applicant Signature _____ Date _____

Section II: Supervising Pharmacist (Pharmacist in Charge) Information

Instructions to Supervising Pharmacist: Complete Section II. Be sure to sign and date the attestation. Every pharmacist at this pharmacy establishment that will supervise this individual must also sign and date the attestation at the end of the form. You must keep a copy of this form along with any supporting documentation and be prepared to submit copies of this form and any supporting documentation directly to the New York State Education Department and Department of Health upon request.

Note: Including unlicensed assistants and temporarily-licensed pharmacy technicians, each pharmacist may supervise **no more** than four individuals at one time. You must list every temporarily-licensed pharmacy technician employed at this location on a Online Supervising Pharmacist Site Log (www.op.nysed.gov/COVID-19tplt.html). Any changes to this information must be submitted within 24 hours using the Online Supervising Pharmacist Site Log.

1. Birth Date Month Day Year 4. New York State Pharmacist License Number

2. Print Full Name as it Appears on Your New York State Pharmacist License

Last

First

Middle

5. Telephone/Email Address

Daytime Phone

Home or Business

3. Mailing Address Home or Business
(You must notify the Department within 30 days of any address or name changes)

Area Code Phone

Email Address (please print clearly)

Home or Business

Line 1

Line 2

Line 3

City

State ZIP Code

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

6. Pharmacy establishment where the temporarily-licensed pharmacy technician is to be employed and supervision occurs:

Name _____

Address _____

Telephone _____ Fax _____ Email _____

Web Address (if available) _____ Pharmacy Registration Number _____

Supervising Pharmacist's Attestation

Check each to acknowledge your responsibilities in the employment of the temporarily-licensed pharmacy technician named on this form.

- I attest that such Temporarily-Licensed Pharmacy Technician (TLPT) holds a certification from a nationally accredited pharmacy technician certification program acceptable to the Department of Health in consultation with the Department of Education; is of good moral character; and has received: (1) training in techniques, indications, precautions, contraindications, and infection control practices; (2) training in use of personal protective equipment sufficient to provide the basic level of competence for such tasks; (3) a minimum of six hours of ACPE approved, immunization-related continuing pharmacy education; (4) New York State's COVID-19 Vaccine Training for Vaccinators Training Module (which includes infection control and PPE procedures); and (5) a current certificate in basic cardiopulmonary resuscitation, which at a minimum must include a certification in basic cardiopulmonary resuscitation by an online program that has received accreditation from the American Nurses Credentialing Center, the Accreditation Council for Pharmacy Education (ACPE), or the Accreditation Council for Continuing Medical Education.
- I attest that I have informed the aforementioned applicant that this is a temporary license only for the purposes of administering the COVID-19 vaccination pursuant to the provisions of Executive Order 202.90 and/or subsequent orders, and that holders of this temporary license may not use the title, nor practice as "Registered Pharmacy Technicians," who, effective April 25, 2021, are licensed pursuant to Chapter 414 of the Laws of 2019.
- I attest that the TLPT's conduct, activities or services will be limited to the administration of COVID-19 vaccinations at Points of Dispensing (POD) sites overseen or approved by the New York State Department of Health or local health departments and operated under the medical supervision of licensed physicians, licensed physician assistants, or certified nurse practitioners, and at pharmacy establishments under the direct personal supervision of a licensed and currently registered pharmacist. I further attest that, if performing such services at a POD, the TLPT will work under the direct personal supervision of a licensed and currently registered pharmacist.
- I attest that I, and any other pharmacist in this authorized setting, will each supervise no more than **four** unlicensed assistants and TLPTs at one time.

I hereby certify that to the best of my knowledge and belief the information on this form is a true statement.

Signature of Supervising Pharmacist

Date

Print Name

Licensed Pharmacist Attestation - Each Pharmacist that can supervise this individual MUST sign this form. Attach Additional Sheets if necessary.

I have personally reviewed this Temporarily-Licensed Pharmacy Technician (TLPT) application. I understand that while overseeing this individual, I must provide direct personal supervision and I am fully responsible for this individual's actions as a TLPT. In addition, I agree that including the applicant named on this form, I will supervise no more than four individuals, including unlicensed assistants and TLPTs, at one time

I attest that the above statement is true.

Signature of Licensed Pharmacist

Date

Print Name

NYS Pharmacist license number

I attest that the above statement is true.

Signature of Licensed Pharmacist

Date

Print Name

NYS Pharmacist license number

I attest that the above statement is true.

Signature of Licensed Pharmacist

Date

Print Name

NYS Pharmacist license number

I attest that the above statement is true.

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Print Name

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