PHARMACIST'S INFORMATION FORM
DRUG THERAPY MANAGEMENT

Each pharmacist who is to perform drug therapy management under this Physician- Pharmacist Agreement must complete a Pharmacist Information Form. The purpose of the form is to provide information to the Board of Pharmacy so that the Board may determine if each pharmacist has the basic qualifications to perform under this Physician-Pharmacist Agreement. The Board of Pharmacy must approve each pharmacist.

Pharmacist's Name_____ _____ _____ _____
Last First Middle Generation (Sr., Jr., etc.)

1. Status of Pharmacist's License.

A. License Number:_____

B ☐ I have not had a public final order disciplining my pharmacist's license in Maryland or in any other state within the 5 years immediately preceding this application. If you have had a public final order disciplining your pharmacist's license within the 5 years immediately preceding this application, please stop here. You are not eligible to provide drug therapy management.

☐ I was disciplined by the Board of Pharmacy or by any other state more than 5 years ago and currently my license has limitations place on it. If you indicated that you currently have limitation placed on your pharmacist's license, please stop here. You are not eligible to provide drug therapy management.

2. Education and Training.

Please feel free to attach an additional document if more space is required to answer the following questions. Be sure that you make clear which answer accompanies which question.

☐ I possess a Doctor of Pharmacy degree. (If you checked this box, please skip to section 3.)

School from which degree obtained:_____

Year that degree was obtained:_____

☐ I possess a Bachelor of Science in Pharmacy degree and I have training in the areas listed below. I am providing documentation for each item listed below and/or an explanation (a Formal Job Description or a Job Performance Evaluation Form from the pharmacist's employer, listing these tasks would suffice).

A. Designing, implementing, monitoring, evaluating, and modifying or recommending modifications in drug therapy to ensure effective, safe, and economical patient care.

B. Identifying, assessing, and solving medication-related problems, and providing clinical judgments as to the continuing effectiveness of individualized therapeutic plans and intended therapeutic outcomes.

C. Conducting appropriate physical assessments, evaluating patient problems, and ordering and monitoring medications and laboratory tests in accordance with established standards of practice.

D. Monitoring patients and patient populations regarding the purposes, uses, effects, and pharmacoeconomics of their medications and related therapy.

E. Providing emergency care including cardiopulmonary resuscitation.

F. Using clinical data to optimize therapeutic drug regimens.

G. Documenting interventions and evaluating pharmaceutical care outcomes.

3. Advanced Training.

What type of specialty training have you completed?

_____

_____

_____

_____

Please indicate that you possess or have completed at least one of the following advanced training programs or certification processes and attach any necessary documentation that indicates name, nature, completion date, expiration date as applicable:

☐ The Board of Pharmacy Specialties Certification program

☐ The American Society of Consultant Pharmacist's Certified Geriatric Practitioner certification program

☐ A residency offered by a body accredited by the Accreditation Council on Pharmacy Education (accrediting bodies for residencies include organizations such as the American Pharmaceutical Association and the American Society of Health-Systems Pharmacists)

☐ Other (provide description, issue date/completion date, and Expiration date, as applicable):_____

4. Hours of Experience (Please check at least one).

☐ I have successfully completed 1,000 hours of relevant clinical experience.

☐ I have successfully completed 320 hours in a structured experience program such as a residency or certification program.

5. Signature.

By signing this Pharmacist Information Form, I am requesting that I be approved to perform drug therapy management pursuant to the accompanying Physician-Pharmacist Agreement and protocol or protocols. I solemnly affirm under the penalties of perjury that the contents of this application are true to the best of my knowledge, information, and belief.

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Signature Date

Mail to: Maryland Board of Pharmacy, P.O. Box 2051, Baltimore, MD 21203-2051.