New Jersey Office of the Attorney General
Division of Consumer Affairs
Board of Pharmacy
124 Halsey Street, 6th Floor, Newark, NJ 07102
(973) 504-6450

Collaborative Practice Pre-Approval Application

This application is the first step that a pharmacist must take in the process of entering into a Collaborative Practice Agreement with a physician for patient drug therapy management. This application must be completed in its entirety, and submitted to the Board of Pharmacy for review. Please include any supporting documentation which is required. Completed applications will be reviewed by the Board, and if approved, the applicant pharmacist will receive a registration card indicating that he/she is authorized to enter into Collaborative Practice Agreements with physicians to provide patient drug therapy management. There is no charge for this registration, which will need to be renewed at the same time as the pharmacist's license to practice pharmacy.

Pharmacist's name:

Pharmacist's address:

Pharmacist's license number: *List all of the states in which you are licensed as a pharmacist. (Attach additional sheets as necessary.)*

License number:_____ State: _____

License number:_____ State: _____

License number:_____ State: _____

1) Is your license in good standing in each state in which you are licensed as a pharmacist? ☐ Yes ☐ No
If "No," provide a detailed explanation.

2) Are there currently any restrictions or conditions on your license in any state in which you are licensed to practice pharmacy? ☐ Yes ☐ No
If "Yes," provide a detailed explanation.

3) Pursuant to N.J.A.C. 13:39-13.3, you must provide documentation indicating successful completion of at least one of the following: *Please check all that apply.*

- ☐ A certificate training program offered by an American Council of Pharmaceutical Education-approved provider.
- ☐ A post-graduate residency program accredited by the American Society of Health-System Pharmacists.
- ☐ A certification program offered by the Board of Pharmacy Specialties.

Please include documentation relating to successful completion of each item selected with this application. Also, indicate the dates of certificate validity, if applicable.

* Please note that a pharmacist granted authorization to engage in collaborative drug therapy management pursuant to this section shall be required to provide every biennial renewal period satisfactory proof of 10 credits of continuing education (C.E.) in each of the disease state(s) or condition(s) identified in the Collaborative Practice Agreement. In the event the Collaborative Practice Agreement covers a disease state or condition that has multiple co-morbidities, the C.E. requirement can be satisfied by obtaining 10 credits in any one of the disease states or conditions. The pharmacist may have the option to divide those 10 credits in any one of the co-morbid disease states or conditions defined in the Collaborative Practice Agreement.

I do solemnly swear or affirm that the answers and statements made in this form are true and correct to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny or withdraw approval to function as a participant in a Collaborative Practice Agreement. I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____	_____	_____
Name of pharmacist (please print)	Signature of pharmacist	Date

Subscribed and sworn to me this_____

day of _____ , 20 _____

Affix seal here

_____

Name of Notary Public (please print)

_____

Signature of Notary Public

Please make sure that you are familiar with the rules regarding Collaborative Practice recordkeeping requirements, etc. The Board may request copies of records at any time.

http://www.nj.gov/lps/ca/chapters/Chapter%2039%20State%20Board%20of%20Pharmacy.pdf