State of New Hampshire  
Board of Pharmacy  
7 Eagle Square  
Concord, NH  03301  
Tel: (603) 271-2350    Fax: (603) 271-2856  
Website: www.oplc.nh.gov/pharmacy/

COLLABORATIVE PHARMACY PRACTICE APPLICATION

PLEASE PRINT CLEARLY - ILLEGIBLE, INCOMPLETE OR APPLICATIONS WITHOUT THE REQUIRED ATTACHMENTS AS NOTED ON PAGE 2 CANNOT BE ACCEPTED.

1. GENERAL INFORMATION

Applicant’s Name    First    Middle    Last

Mailing Address

NH Pharmacist License Number    Home or Cell Phone #    Work Phone #    E-mail Address (Must be entered to receive your updated license with CPP endorsement):

2. CURRENT PHARMACY EMPLOYMENT ASSOCIATED WITH THIS COLLABORATIVE AGREEMENT

Name of NH Pharmacy

Complete Mailing & Physical Address of NH Pharmacy

3. PROFESSIONAL LIABILITY INSURANCE AND CARDIOPULMONARY RESUSCITATION (CPR) CERTIFICATION

I have at least $1,000,000 of professional liability insurance with the following insurance provider ___________________________________________.

* You must attach a copy of your certificate of insurance to this application.

If also administering vaccines, I have current CPR certification, which includes the required ‘hands-on’ training which must be completed every 2 years, from (please check one):

☐ American Heart Association    ☐ American Red Cross    ☐ Not Applicable – I Do Not Administer Vaccines

* If administering vaccines, you must attach a copy of your certificate of completion of CPR training or a copy of the back & front of your signed CPR Card, which show it was completed in the past 2 years (i.e. has not passed the ‘recommended date for refresher training’).

4. PRACTICE DISCIPLINE FOR THIS COLLABORATIVE PRACTICE AGREEMENT (ONLY ONE PRACTICE DISCIPLINE ALLOWED PER APPLICATION)

Check only one:

☐ Asthma    ☐ Anticoagulation    ☐ COPD    ☐ Diabetes    ☐ Hyperlipidemia    ☐ Hypertension

☐ Other (Describe):__________________________________________________________

FORM: CPP-1 (Rev. 05/19)

APPLICATION CONTINUED ON NEXT PAGE ➤
5. SUMMARY OF EDUCATION, TRAINING, AND EXPERIENCE RELATED TO RESPONSIBILITIES TO PERFORM VIA THE COLLABORATIVE PRACTICE AGREEMENT:

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6. APPLICANT ATTESTATION STATEMENT:

My signature below affirms that the answers and statements made on this application are true and correct to the best of my knowledge and belief. I also understand that pursuant to RSA 318:26-a, the Board must be notified within 15 days of any changes related to your collaborative practice agreement or in the information contained on this form. Failure to notify the Board could result in disciplinary action and/or sanctions.

Signature: _________________________________________ Date: __________________________

7. EMPLOYER ATTESTATION STATEMENT:

As owner / chief administrative officer of _________________________________________________ I certify that my Company agrees to be in compliance with all federal, state, and local laws related to this agreement. I have read this application and all of the statements made on it, reviewed all submitted supporting documents, attest that to the best of my knowledge, all provided information is true and accurate. As the owner/corporate representative of this organization, my signature below acknowledges my/the corporation’s responsibilities as the permit holder, including all of the corporate/permit holder duties and responsibilities noted in NH RSA 318:38 and Ph 704.11(d).

Signature
Of Organization Representative: __________________________________________ Title: __________________________________________ Date: __________________________

* LIST OF SUPPORTING DOCUMENTS WHICH MUST BE INCLUDED WITH THE APPLICATION:

Attach each of the following and label the top right of each attachment with the corresponding letter below (i.e. “Attachment A”, “Attachment B”, etc.)

A. Copy of Signed Collaborative Agreement;
B. Copy of Professional Liability Insurance Coverage/Certificate;
C. Copy of Policy and Procedures governing the Collaborative Practice Agreement;
D. Copy of Policy and Procedures for QA/CSI program
E. Copy of Patient Consent Form;
F. List of all Providers Whom Are Party to the Agreement – Full Name, Address and NH License;
G. If administering vaccines, a copy of your certificate of completion of CPR training or a copy of the back & front of your signed CPR Card, which shows it was completed in the past 2 years (i.e. has not passed the ‘recommended date for refresher training’).