



# Newfoundland & Labrador Pharmacy Board

Apothecary Hall  
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St. John's, NL A1E 1B3

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## Application for Authorization to Administer Drug Therapy by Inhalation or Injection

### Full Name:

\_\_\_\_\_  
Last Name First Name & Middle Initial Registration #

### Home Address:

\_\_\_\_\_  
Street Address P.O. Box (if applicable)

\_\_\_\_\_  
City/Town & Province Postal Code Country

\_\_\_\_\_  
Home Phone Number Home Email Address

### Employment Information:

\_\_\_\_\_  
Name of Primary Place of Employment

\_\_\_\_\_  
Street Address P.O. Box (if applicable)

\_\_\_\_\_  
City/Town & Province Postal Code Country

\_\_\_\_\_  
Business Phone Number Business Fax Number Business Email Address

### Certifications:

- I certify that the information contained in this application is complete and correct and I recognize that providing false or incomplete information on the application may be cause for revocation of authorization or an allegation of conduct deserving of sanction.
- I have enclosed:
- The signed Declaration Form (*see page 2*);
  - Proof of successful completion of an education and training program on the administration of injections that has received CCCEP Competency-Based (Stage 2) Accreditation, completed within one year of application.;
  - Proof of current certification in CPR Level C or HCP and Emergency or Standard First Aid from a recognized provider (e.g. St. John Ambulance, Canadian Red Cross); and
  - The appropriate fee, as indicated in the *NLPB Schedule of Fees*.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date Signed

**Fee Paid By:**  Cash, Cheque or Money Order  VISA  Mastercard

**Please Print Full Name on Card:** \_\_\_\_\_

\_\_\_\_\_  
Card # Expiry Date CVV # (on back of card)

**Registrants are reminded that authorization is not effective until notification that the application has been approved is received from the NLPB.**

**Application for Authorization to Administer Drug Therapy by Inhalation or Injection**  
**Declaration Form**

I,

\_\_\_\_\_

Please Print Full Name

\_\_\_\_\_

Registration Number

a registered pharmacist with the Newfoundland and Labrador Pharmacy Board, declare that:

- I am the person referred to in the documents submitted in support of my application, and that these documents present a true and accurate account of my qualifications.
- I have reviewed the *Standards for the Safe and Effective Administration of Drug Therapy by Inhalation or Injection* and will abide by the standards, limits and conditions that apply to the administration of drugs by injection and restrict my practice to those areas in which I am competent.
- I have successfully completed an education and training program on the administration of injections that has received CCCEP Competency-Based (Stage 2) Accreditation.
- I have successfully completed certification in CPR Level C or HCP and Emergency or Standard First Aid from a recognized provider and will maintain this certification for the duration of my authorization. I understand that if I am unable to provide proof of certification, my authorization to administer drug therapy by inhalation or injection will be cancelled.
- I will not administer any drug therapy by inhalation or injection prior to receiving notification from the Newfoundland and Labrador Pharmacy Board of their approval of my application to administer injections.
- I understand that my eligibility for authorization is subject to audit and that false or misleading statements concerning my qualifications may be considered grounds for an allegation of conduct deserving of sanction.

I make this declaration, conscientiously believing it to be true and knowing that it is of the same force and effect as if made under oath.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date