



Newfoundland & Labrador Pharmacy Board

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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

Certifications:

By signing below, 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 on page 2;
 - proof of **EITHER**:
 - graduation from a CCAPP-accredited pharmacy program where education and training on the administration of injections is a component of the core curriculum; or
 - successful completion of a CCCEP-accredited education and training program on the administration of injections that was completed within one year of the date of application; and
 - proof of current certification in First Aid and CPR, at a level equivalent to the St. John Ambulance or Red Cross Emergency or Standard First Aid and CPR/AED Level C. NOTE: only in-person or blended learning courses will be accepted.

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 they have received notification from NLPB that the application has been approved.

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 of Practice - 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 EITHER:
 - o graduated from a CCAPP-accredited pharmacy program where education and training on the administration of injections is a component of the core curriculum; or
 - o successfully completed a CCCEP-accredited education and training program on the administration of injections within one year of the date of application.
- I have successfully completed First Aid and CPR, at a level equivalent to the St. John Ambulance or Red Cross Emergency or Standard First Aid and CPR/AED Level C and understand that I am responsible for maintaining this certification.
- I will not administer any drug therapy by inhalation or injection prior to receiving notification from the Newfoundland and Labrador Pharmacy Board that my application has been approved.
- 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