MAINE
BOARD OF PHARMACY

Application for
Collaborative Drug Therapy Management

Do not return the informational pages with your application; it is for your information only

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345
Office Direct Line (207) 624-8620 or Department Main Receptionist (207) 624-8603
TTY users call Maine relay 711
FAX (207) 624-8637
Web address: www.maine.gov/professionallicensing
Email: pharmacy.lic@maine.gov

FAQ's
Have a question? Please visit our list of Frequently Asked Questions.

Can I come to Gardiner to drop off my application?
No, the Gardiner Annex is closed to the public until further notice due to the Covid-19 pandemic. Please mail your paper application to our mailing address 35 State House Station, Augusta, ME 04333.

APPLICATION INSTRUCTIONS

COLLABORATIVE DRUG THERAPY MANAGEMENT

For individuals who hold a current Maine Pharmacist License (must be an unrestricted license)

The following is a guideline to assist in your application process. It does not, however, replace the requirements outlined in the Maine Board of Pharmacy Laws and Rules. Please review them carefully for more detailed and clarifying information.

CHECKLIST:

- ☐ Application fully completed (No fee is required)
- ☐ Copy of the Collaborative Practice Agreement, signed and dated
- ☐ Proof of Professional Liability Insurance
- ☐ Copy of the Treatment Protocol, signed and dated
- ☐ Proof of College Education, if applicable
- ☐ Board of Pharmacy Specialties Certificate, if applicable
- ☐ Evidence of completion of an accredited residency program, if applicable
- ☐ CE Certificates, as applicable

NOTICE For authorization to practice Collaborative Drug Therapy Management you must hold a valid Maine Pharmacist license. Applications to apply for an initial Maine Pharmacist license by: Examination, Score Transfer, or by Reciprocity/Endorsement are available online at www.maine.gov/professionallicensing.

Your application will be considered incomplete and will be returned if this application is: incomplete, altered (including use of any white out), defaced, or compromised. Examples of an incomplete application include, but are not limited to, unanswered questions requiring a response, lack of appropriate signature, information is illegible and required supporting documents not included.

CONTINUING EDUCATION—For purposes of renewing your authorization to practice Collaborative Drug Therapy Management

You must satisfy the Continuing Education requirements pursuant to 32 MRS §13735, which require you to complete at least 5 of the 15 continuing education hours in the areas of practice covered by your collaborative agreement. Please be sure to review this requirement carefully.

APPLICATION PROCESSING TIME

Your application has a greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending for review or under review. Once reviewed and if everything about your application is complete and complies with requirements, the license will be issued and the status will show as ACTIVE. If your application is incomplete, you will be notified in writing.

Please refrain from calling our office to "check" on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

IMPORTANT INFORMATION REGARDING YOUR LICENSE: The Office no longer prints licenses. Upon issuance of your license, you will be notified by email using the email address you provide in this application from *noreply@maine.gov* that your license has been issued with your license attached to the email (a paper license will not be sent by regular mail). The email with your license will contain the access code that is required to renew your license online when the time comes. You may also update your contact information and email address using this access code, go online to www.maine.gov/professionallicensing.

Approximately sixty (60) days prior to the expiration of your license a courtesy renewal reminder will be sent to you by email. It is important that you maintain a current email on file or risk not receiving the renewal reminder. You do not need to wait for a renewal reminder to renew your license. The online renewal opens sixty (60) days prior to the license expiring and you may renew online anytime.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE APPLICATION

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME *FIRST* *MIDDLE INITIAL* *LAST*			
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH *mm / dd / yyyy*		SOCIAL SECURITY NUMBER - -	
CONTACT ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL (Note: Your license will be sent to this email)	
BACKGROUND CHECK NOTICE: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.			

MAINE BOARD OF PHARMACY

COLLABORATIVE DRUG THERAPY MANAGEMENT

Office Use Only:
CDT NO FEE

Office Use Only:

Lic.# CDT_____

Please complete the designation section applicable to your qualifications.

Pursuant to 32 MRS §13842, section 1, your pharmacist license must be current and without restrictions.

Pursuant to 32 MRS §13842, section 2, to qualify you must demonstrate one of the following. Please complete the appropriate section of the application below.

A. Possesses certification from the Board of Pharmacy Specialties or successor organization or has completed an accredited residency program. If the residency program is not in the area of practice covered by the agreement, the pharmacist must complete a continuing education certificate program of at least 15 hours of continuing education in each clinical area of practice covered by the agreement;

B. Has graduated with a Doctor of Pharmacy degree from a college of pharmacy accredited by the American Council on Pharmaceutical Education, has 2 years of professional experience and has completed a continuing education certificate program of at least 15 hours of continuing education in each clinical area of practice covered by the agreement; or

C. Has graduated with a Bachelor of Science in Pharmacy degree from a college of pharmacy accredited by the American Council on Pharmaceutical Education, has 3 years of professional experience and has completed a continuing education certificate program of at least 15 hours of continuing education in each clinical area of practice covered by the agreement.

SECTION 1: Pathway #1

Board of Pharmacy Specialties Certification or by having completed an Accredited Residency Program. (Reference 32 M.R.S. §13842(2)(A))

Check one of the following:

☐ **Check here** if applying by certification from the Board of Pharmacy Specialties. *Submit a copy of the certificate with this application.*

Certification #:_____

Date Issued:_____

☐ **Check here** if applying by completion of an accredited resident program in the area of practice covered by the agreement. *Submit documentation of the resident program to verify this requirement.*

Where was the resident program completed:

_____

_____

Date Completed:_____

☐ **Check here** if the resident program area of practice **did not cover the practice area identified in the agreement**. If so, you must complete a continuing education certificate program of at least 15 hours in each clinical area of practice covered by the agreement. *Submit a copy of the CE certificate with this application.*

SECTION 1: Pathway #1 - Board of Pharmacy Specialties Certification or by having completed an Accredited Residency - Con't

Continuing Education Certificate Program — You must have completed at least 15 hours of continuing education in each clinical area of practice covered by the agreement. List each CE course below. Use a separate sheet of paper if needed.	
#1 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#2 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#3 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

SECTION 1: Pathway #1 - Board of Pharmacy Specialties Certification or by having completed an Accredited Residency - Con't

Continuing Education Certificate Program — You must have completed at least 15 hours of continuing education in each clinical area of practice covered by the agreement. List each CE course below. Use a separate sheet of paper if needed.	
#4 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#5Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#6 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

SECTION 2: Pathway #2

College Education with a Doctor of Pharmacy Degree from a college of pharmacy accredited by the American Council of Pharmaceutical Education with 2 years of professional experience and completed at least 15 hours of continuing education in each clinical area of practice covered by the agreement. (Reference 32 MRS §13842(2)(B))

College Degree Name of Accredited College of Pharmacy		Date Degree Awarded *mm / dd / yyyy*
College Contact Address, City, State and Zip Code		
City	State	Zip Code

Evidence of 2 years of professional experience *(complete as many as required below)* *Use a separate sheet of paper if needed.*		
#1 Name of entity where you obtained your pharmacy professional experience		
Contact Address		
City	State	Zip Code
Professional Experience Began (Date)		Professional Experience Ended (Date)
mm / dd / yyyy		*mm / dd / yyyy*
#2 Name of entity where you obtained your pharmacy professional experience *Use a separate sheet of paper if needed.*		
Contact Address		
City	State	Zip Code
Professional Experience Began (Date)		Professional Experience Ended (Date)
mm / dd / yyyy		*mm / dd / yyyy*
#3 Name of entity where you obtained your pharmacy professional experience *Use a separate sheet of paper if needed.*		
Contact Address		
City	State	Zip Code
Professional Experience Began (Date)		Professional Experience Ended (Date)
mm / dd / yyyy		*mm / dd / yyyy*

SECTION 2: Pathway #2 - College Education - Doctor of Pharmacy Degree - Con't

Continuing Education Certificate Program — You must have completed at least 15 hours of continuing education <u>in each clinical area of practice covered by the agreement.</u> List each CE course below. Use a separate sheet of paper if needed.	
#1 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#2 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#3 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

SECTION 2: Pathway #2 - College Education - Doctor of Pharmacy Degree - Con't

Continuing Education Certificate Program—You must have completed at least 15 hours of continuing education <u>in each clinical area of practice covered by the agreement.</u> List each CE course below. Use a separate sheet of paper if needed.	
#4 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#5 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#6 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

SECTION 2: Pathway #2 - College Education - Doctor of Pharmacy Degree - Con't

Continuing Education Certificate Program—You must have completed at least 15 hours of continuing education <u>in each clinical area of practice covered by the agreement.</u> List each CE course below. Use a separate sheet of paper if needed.	
#4 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#5 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

#6 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** copy of the applicable CE Certificate with this application.

SECTION 3: Pathway #3

College Education with a Bachelor of Science in Pharmacy Degree from a college accredited by the American Council on Pharmaceutical Education with 3 years of professional experience and completed at least 15 hours of continuing education in each clinical area of practice covered by the agreement. (Reference 32 M.R.S. §13842(2)(C))

College Degree Name of Accredited College of Pharmacy		Date Degree Awarded *mm / dd / yyyy*
College Contact Address		
City	State	Zip Code

Evidence of 3 years of professional experience *(complete as many as required below)*	
#1 Name of entity where you obtained your pharmacy professional experience	
Contact Address	
City	State / Zip Code
Professional Experience Began (Date)	Professional Experience Ended (Date)
mm / dd / yyyy	*mm / dd / yyyy*
#2 Name of entity where you obtained your pharmacy professional experience	
Contact Address	
City	State / Zip Code
Professional Experience Began (Date)	Professional Experience Ended (Date)
mm / dd / yyyy	*mm / dd / yyyy*
#3 Name of entity where you obtained your pharmacy professional experience	
Contact Address	
City	State / Zip Code
Professional Experience Began (Date)	Professional Experience Ended (Date)
mm / dd / yyyy	*mm / dd / yyyy*

SECTION 3: Pathway #3 - College Education - Bachelor of Science Degree - Con't

Continuing Education Certificate Program—You must have completed at least 15 hours of continuing education in each clinical area of practice covered by the agreement. List each CE course below. Use a separate sheet of paper if needed.	
#1 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** a copy of the applicable CE Certificate with this application.

#2 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** a copy of the applicable CE Certificate with this application.

#3 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** a copy of the applicable CE Certificate with this application.

SECTION 3: Pathway #3 - College Education - Bachelor of Science Degree - Con't

Continuing Education Certificate Program — You must have completed at least 15 hours of continuing education in each clinical area of practice covered by the agreement. List each CE course below. Use a separate sheet of paper if needed.	
#4 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** a copy of the applicable CE Certificate with this application.

#5 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** a copy of the applicable CE Certificate with this application.

#6 Full Name of CE Course	
Date Completed	# Hours
mm / *dd* / *yyyy*	

List below each clinical area of practice this CE course covers.	**Submit** a copy of the applicable CE Certificate with this application.

SECTION 4: Collaborative agreement and treatment protocol submission.

In addition to the required licensure qualification documents, the following is also required. Failure to include all document submissions with this application may render your application incomplete and may be returned.

✓ Enclosed is a copy of the collaborative agreement as required by 32 MRS §13843, section 1 and Pharmacy Rule Chapter 39, Section 2(3).

I, the applicant, understand that I must file proper notification of any amendment to this agreement as required by Pharmacy Rule Chapter 39, Section 5(1).

✓ Enclosed is proof of professional liability insurance covering the scope of the collaborative practice as required by 32 MRS §13843(5) and Pharmacy Rule Chapter 39, Section 3(9).

I, the applicant understand that I must file proper notification of any change to the liability insurance as required by Pharmacy Rule Chapter 39, section 5 (3).

✓ Enclosed is a copy of the treatment protocol as required by 32 MRS §13845 and Pharmacy Rule Chapter 39, Section 2(3).

I, the applicant, understand that I must file proper notification of any amendment to the treatment protocol as required by Pharmacy Rule Chapter 39, section 5(2).

SECTION 5: Pharmacist License Information

Do you currently hold a valid Maine Pharmacist License? ☐ Yes ☐ No

License # _____ Expiration Date: _____

If you responded, no: Your application to apply for a Maine Pharmacist License must accompany this application. Visit www.maine.gov/professionallicensing for the application.

SECTION 6: NOTICES

Please Note:
Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.

You can access this Law for your review at:
http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html

SECTION 7: EVIDENCE OF LIABILITY INSURANCE

A copy of the professional practice liability insurance policy covering the scope of collaborative practice must accompany this application. The insurance must, at a minimum, include the following:

Name of Insurance Company:	
Address of the Insurance Company:	
Effective Date of the policy:	Expiration Date of the policy:
Policy Amount:	

SECTION 8: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), defaced, or compromised will not be accepted and will be returned. This includes, but is not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing required supporting documents, and/or missing or wrong fee.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Printed Name of Applicant	Title
Signature of Applicant	Date