MAINE
BOARD OF PHARMACY

Applying for Certificate of Administration of Drugs and Vaccines Reinstatement

(91 days up to 2 years from Expiration)

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 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

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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
CERTIFICATE OF ADMINISTRATION OF DRUGS AND VACCINES

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 with required fee

☐ Copy of the 20 hour course of study or college transcript. Training must be within 3 years immediately preceding this application for a certificate of administration.

☐ Copy of the Life Support Training (CPR) is enclosed with this 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 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.

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.

NOTICE: In Maine, you must be authorized to Collaborative Drug Therapy Management by virtue of additional license(s). Applications to apply for an initial licensure as Collaborative Drug Therapy Management are available online at www.maine.gov/professionallicensing

Maine Pharmacist license by: Examination, Score Transfer, or by Reciprocity/Endorsement are available online at: www.maine.gov/professionallicensing.

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. 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 includes, but is not limited to, unanswered questions requiring a response, lack of appropriate signature, information is illegible and required supporting documents not included.

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 **(Your license will be emailed)**	
BACKGROUND CHECK NOTICE: Pursuant to 5 MRSA §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

APPLICATION FOR REINSTATEMENT CERTIFICATE OF ADMINISTRATION OF DRUGS AND VACCINES

REQUIRED FEE: $50.00 (Non-Refundable)

Office Use Only:
ADV 2090 - $50

Office Use Only:
Check #_____
Amount:_____
Cash #_____
Lic. #_____
Issue Date_____

PAYMENT OPTIONS:
Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*

I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER the following amount: $_____

☐ **I understand that fees are non-refundable**

Card number: *XXXX-XXXX-XXXX-XXXX* Expiration Date *mm / yyyy*

SIGNATURE **DATE**

YOU MUST COMPLETE SECTION 1 OR SECTION 2, WHICHEVER APPLIES.

Your PharmD transcripts and evidence of having completed a 20 hour course of study **must** accompany this application; otherwise your application will be deemed incomplete and returned without processing. The PharmD program or the 20 hour course of study must meet the didactic & practical requirements described in 32 MRSA § 13832(4).

32 MRSA § 13832(4)

Didactic; practical course. Satisfactorily complete a didactic and practical course approved by the board that includes the current guidelines and recommendations of the federal Department of Health and Human Services, Centers for Disease Control and Prevention, the American Council on Pharmaceutical Education or a similar health authority or professional body, and that includes, but is not limited to, disease epidemiology, indications for use of vaccines, vaccine characteristics, injection techniques, adverse reactions to vaccines, emergency response to adverse events, immunization screening, informed consent, record keeping, registries, including the immunization information system established under Title 22, section 1064, registry training and reporting mechanisms, including reporting adverse events, life support training, biohazard waste disposal and sterile techniques and related topics.

Pursuant to 32 MRSA Sub-Section 13832(3) training must have been obtained within 3 years immediately preceding this application. In addition:

- A PharmD transcript must clearly state your name and date the degree was awarded.
- The 20 hour course of study must clearly state your name, date of completion and the number of hours completed.

SECTION 1: TRAINING— Complete this section IF YOU HAVE COMPLETED A 20-HOUR COURSE OF STUDY (32 MRSA §13832, section 3)

SECTION 2: TRAINING— Complete this section if applying with a PharmD degree.

Please list the name of the course, the course sponsor and date course completed.

□ Check here if this is an *American Council on Pharmaceutical Education (ACPE)* course.

Course name:_____

Date Completed:_____

□ Check here if this is a course sponsored or approved by the *Centers for Disease Control and Prevention*.

Course name:_____

Date Completed:_____

□ Check here if *Other*: - please provide a copy of the course syllabus or course content.

Course sponsor:_____

Course name:_____

Date Completed:_____

College of Pharmacy	Date Degree Awarded	Semester Immunology was taken

College Contact Address PO Box or Street Address		
City	State	Zip Code

SECTION 3: LIFE SUPPORT TRAINING (CPR) — Evidence of completing cardiovascular life support training.

Please complete the following.

☐ Check here if this is an *American Heart Association* course.

Course name:_____

Date Completed:_____

☐ Check here if this is an *American Red Cross* course.

Course name:_____

Date Completed:_____

☐ Check here if *Other*:

Course sponsor:_____

Course name:_____

Date Completed:_____

SECTION 4: For Your Information on Treatment Protocol

The following is an excerpt from 32 MRS §13833:

"The pharmacist shall administer drugs and vaccines in compliance with a treatment protocol established by a practitioner authorized under the laws of this State to order administration of those drugs and vaccines approved by the board. A copy of the treatment protocol must be submitted to the board…."

SECTION 5: 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 6: 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 7: 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 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