

MONTANA BOARD OF PHARMACY
P. O. Box 200513
(301 S PARK, 4TH FLOOR HELENA MT 59601- Delivery)
Helena, Montana 59620-0513
PHONE (406) 841-2356 FAX (406) 841-2344
E-MAIL: dlibspha@mt.gov WEBSITE: www.pharmacy.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

APPROVAL REQUIREMENTS:

- ◆ Hold an active, unrestricted Montana pharmacist license.
- ◆ Proof of completion of five years of clinical practice experience or have completed a pharmacy residency and two years clinical practice experience and submit a copy of an active certificate from one of the following:
 - ◆ BPS certification; **or**
 - ◆ Nationally recognized certification in an area of practice as approved by the Board and the Board of Medical Examiners (BME)
- ◆ Submit a signed collaborative practice agreement to the Board of Pharmacy that includes a description of the type of supervision the collaborating physician will exercise over the clinical pharmacist practitioner
- ◆ Following approval by the Board of Pharmacy, submit the application and collaborative practice agreement to the BME for approval; and
- ◆ Appear before the Board of Pharmacy and/or BME if requested.

FEE: \$25.00 (Non-Refundable) - Application Fee

ADDITIONAL RULES AND STATUTES

24.174.525 DEFINITIONS (1) "Board of Pharmaceutical Specialties" (BPS) means an independent nongovernmental certification body that provides recognition of persons involved in the advanced

practice of pharmacy specialties through development and administration, a certification process that is consistent with public policy regarding the credentialing of healthcare professionals.

(2) "Clinical practice experience" means working in a pharmacy practice setting which includes at least 50 percent of time spent in:

(a) communication with healthcare professionals and patients regarding drug therapy, wellness, and health promotion;

(b) designing, implementing, monitoring, evaluating, and modifying or recommending modifications in drug therapy to optimize patient care;

(c) identifying, assessing, and solving medication-related problems and providing a clinical judgment as to the continuing effectiveness of the therapeutic plan;

(d) conducting physical assessment applicable to the area of practice, evaluating patient problems, ordering and monitoring medications, and/or laboratory tests in accordance with established standards of practice;

(e) referring patients to other healthcare professionals as appropriate;

(f) integrating relevant diet, exercise, and other non-drug therapy with pharmaceutical care;

(g) retrieving, evaluating, utilizing, and managing data and professional resources;

(h) documenting interventions and evaluating outcomes; and

(i) integrating national standards for the quality of healthcare.

(3) "Collaborative practice agreement" is defined as set forth in ARM

APPLICATION PROCEDURES

- ◆ When the application file is complete, it will be processed and considered by Board staff for licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- ◆ If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.

PROCESSING PROCEDURES

- ◆ Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.
- ◆ The applicant will be notified in writing of any deficient or missing items from the application file.

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy staff at (406) 841-2356 or 841-2355 or email us at: dlibspha@mt.gov or review the laws and rules at: www.pharmacy.mt.gov

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NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE _____ FAX _____

LICENSE # _____

EMAIL ADDRESS _____

Have you ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Has a licensing agency initiated or completed disciplinary action against any professional or occupational license you have held? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. Yes No

Have you ever voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupation license in anticipation of or during an investigation or disciplinary proceedings or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Has a complaint ever been made against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have any civil legal proceedings been filed against you by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. Yes No

Have you ever been convicted of a misdemeanor or felony crime or do you have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If you answer yes, you must submit a detailed explanation of the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years ago and that resulted in fines of less than \$200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. Yes No

Have you ever been diagnosed with chemical dependency or another addiction, or have you participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. Yes No

Have you ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. Yes No

Have you ever been courts martial or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation from the source. Yes No

Have you ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

Have you ever been censured, expelled, denied membership or asked to resign from a professional organization related to your profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. Yes No

Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. Yes No

Do you have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a detailed explanation and provide documentation from the source. Yes No

Applicant's Printed Name

Applicant's Signature

Date