SPCB SPECIALTY PHARMACY CERTIFICATION BOARD

Employment Verification Form

Please print clearly and neatly. All sections of the form must be completed. Incomplete or illegible applications will not be processed. Please submit a separate form for each employer. ***Self-employed pharmacists please refer to Section C.***

Section A: To be completed by Applicant

Applicant Information

Last Name: First Name: Middle Initial:

Phone: Email:

Employer or Manager Information

Last Name: First Name:

Job Title(s):

Organization Name:

Address:

City: State: Zip:

Phone: Email:

By my signature below, I grant permission to the organization listed above to release to the Specialty Pharmacy Certification Board (SPCB) the information requested on this form for the purposes of verifying my employment and specialty pharmacy practice hours. I also attest that all information provided on this form is accurate and truthful and I acknowledge that failure to submit complete or accurate information may result in disciplinary action, including the suspension or revocation of CSP certification.

Applicant Signature Date

Section B: To be Completed by Employer

Applicants for the Certified Specialty Pharmacist (CSP) certification are required to document at least 3,000 hours of specialty pharmacy practice during the *four (4) years prior to applying for certification*.

I attest that the certification candidate identified in Section A above has completed _____ hours of specialty pharmacy practice during the *four (4) year period prior to the date on this form*. I further attest that I am authorized by the organization listed above to provide the information and verification included on this form.

Employer/Manager Signature Date

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Section C: Self-Employed Pharmacists

Self-employed specialty pharmacists should complete both section A and Section B of this form. Section C should be completed by an individual knowledgeable about the pharmacist's practice.

Information for Individual Completing Section C

Last Name: First Name:

Address:

City: State: Zip:

Phone: Email:

Relationship to Applicant:

I attest that the certification candidate identified in Section A above has completed _____ hours of specialty pharmacy practice during the *four (4) year period prior to the date on this form*.

Signature Date