



Arkansas State Board of Pharmacy
101 East Capitol, Suite 218
Little Rock, AR 72201
501-682-0190 Fax 501-682-0195
 www.arkansas.gov/asbp

<p>FOR BOARD USE ONLY:</p> <p>Drug Therapy or Patient Management? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Program ID #: _____</p>

REQUEST FOR BOARD OF PHARMACY APPROVAL OF CONTINUING EDUCATION

NOTE: This form must reach the Board of Pharmacy office at least 15 days before the CE program is to be held. Requests not received within the 15 days of the date will be returned non-approved.

APPROVAL REQUESTED BY:

Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

Email: _____

This is to affirm that the undersigned will be responsible for assuring that participants are present, the program criteria is appropriate, and that the program will deliver the specified time of continuing education to meet the needs of the participating pharmacists.

Signature of applicant for the C.E. Program Approval: _____

PROGRAM INFORMATION: (Please limit speakers CV's or resumes to 5 pages or less)

Title:
This program is: <input type="checkbox"/> Live <input type="checkbox"/> Audio Visual <input type="checkbox"/> Correspondence
Presenter/Speaker:
If program is <u>audio visual</u> , provide Name of the live moderator:
Date To Be Presented: _____ Begins at: _____ Ends at: _____
Location of Presentation:
Description of Program Content:
Program Objectives and Goals:
Describe The Evaluation Process:
Specify How Accreditation Certification Will Be Presented To Participants:
of Hours Requested: <input type="checkbox"/> 1 hour <input type="checkbox"/> 1 ½ hour <input type="checkbox"/> 2 hours <input type="checkbox"/> Other:

FOR BOARD USE ONLY:	
# of Hours Approved: <input type="checkbox"/> 1 hour <input type="checkbox"/> 1 ½ hour <input type="checkbox"/> 2 hours <input type="checkbox"/> Other:	
Approved By: _____ Executive Director	Date: _____

The individual requesting the CE program must assure that <u>each</u> participant is present and completes this portion of the form.	
Name Of Participant:	AR License #:

PARTICIPANTS MUST KEEP A COPY OF THIS FORM FOR CE VERIFICATION

ARKANSAS STATE BOARD OF PHARMACY

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EXECUTIVE DIRECTOR

CONTINUING EDUCATION APPROVAL

The Arkansas State Board of Pharmacy is pleased to approve the Continuing Education (CE) program on the attached *Request for Approval Form*. Please provide a copy of the approved form to all participants in attendance for your full program that complies with the time frame requested. Please also accept our thanks for your participation in the provision of live continuing education for pharmacists in your community.

The Board provides this reminder that your submission of a CE approval form to the Arkansas State Board of Pharmacy for a specified time (i.e., one hour, etc.) and your signature as the applicant for the approval is your affirmation that you ensure the program will deliver the specified time of continuing education. (e.g., a one-hour program approved by the Board must last sixty (60) minutes.)

NOTICE: If the Board determines that the amount of continuing education requested is not the amount of continuing education that is presented, the Board will rescind the approval and void the hour(s). Additionally, the applicant shall be denied the privilege of requesting future CE approval from the Arkansas State Board of Pharmacy.

If you have questions or concerns, please feel free to contact the Board office at (501) 682-0190.