

ARKANSAS STATE BOARD OF PHARMACY
101 EAST CAPITOL, Suite 218
LITTLE ROCK, AR 72201
Phone: (501) 682-0190 Fax: (501) 682-0195

FOR BOARD USE ONLY:

Drug Therapy or Patient Management: YES NO

Program ID # _____

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 C.E. PROGRAM IS TO BE HELD. REQUESTS NOT RECEIVED WITHIN 15 DAYS OF THE DATE OF THE PROGRAM WILL BE RETURNED NON-APPROVED..

APPROVAL REQUESTED BY:

NAME: _____

PLEASE PRINT

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ FAX #: _____

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

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

PROGRAM INFORMATION: (PLEASE LIMIT SPEAKERS CV'S OR RESUMES TO 5 PAGES OR LESS)

TITLE: _____ PRESENTER/SPEAKER: _____

LOCATION OF PROGRAM: _____

DATE PROGRAM TO BE PRESENTED: _____

PROGRAM BEGINS AT _____ a.m./p.m. AND ENDS AT _____ a.m./p.m.

DESCRIPTION OF PROGRAM CONTENT:

PROGRAM OBJECTIVES AND GOALS:

THE PROGRAM IS: LIVE AUDIO VISUAL CORRESPONDENCE
IF THE PROGRAM IS AN AUDIO VISUAL PRESENTATION PLEASE PROVIDE THE NAME OF THE LIVE MODERATOR: _____

DESCRIBE THE EVALUATION PROCESS:

SPECIFY HOW ACCREDITATION CERTIFICATION WILL BE PRESENTED TO PARTICIPANTS:

NUMBER OF HOURS REQUESTED:

1 HOUR 2 HOURS
 1 ½ HOURS OTHER _____

NUMBER OF HOURS APPROVED:

1 HOUR 2 HOURS
 1 ½ HOURS OTHER _____

APPROVED BY: _____ DATE: _____

EXECUTIVE DIRECTOR



THE INDIVIDUAL REQUESTING THE C.E. PROGRAM MUST ASSURE THAT EACH 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