Continuing Education Committee
Board Approved Provider Description Form
(After this form is completed it shall be forwarded to the Board accompanied by a self-addressed envelope for return.)

PROVIDER NAME__________________________________________ PROGRAM NUMBER________________________
ADDRESS________________________________________________ STATE________________________________________ ZIP_____________

Directions: Please fill out this form for each continuing education program that you develop and conduct as a Board approved provider. Your completed form should be submitted to the Board at least 30 days in advance of the scheduled date for the C.E. activity described. A copy of promotional material should be attached.

PROGRAM TITLE__________________________________________

General Topic Category (check all that apply):

_____ Practice Management  _____ Patient Management/Clinical Topics
_____ Disease States/Therapeutics  _____ Drugs and Dosage Forms
_____ Laws, Rules & Regulations  _____ Other (describe)

Delivery Mode:  _____ Live Program  _____ Home Study  _____ Other (describe)

Date(s)________________________ Location(s)________________________

Sponsor/Co-sponsor(s)_____________________________________

Tuition (Fee): $________________________ Estimated Number of Participants________________________

Amount of Credit________________________ (CEU’s – 1 contact hour equals 0.1 CEU)

Person Completing Form/Title________________________ Date________________________

Telephone No.(s) Day ( )_________________________ Evening ( )________________________

Facsimile No. ________________________________
NOTE: The provider will be directly responsible to the Board of Pharmacy for verification of participation in the program, and the issuance of certificate for hours completed to each participant of said approved program.

Please attach a detailed outline of each program; include goals and objectives and listing of presenters with credentials on opposite side of this page.

Have you ever provided a Board of Pharmacy approved program? YES NO

If YES, please indicate the most recent program number

Please return this completed form along with a self-addressed envelope for return to:

MA Board of Registration in Pharmacy - CE
239 Causeway Street, Suite 200, 2nd Floor
Boston, MA 02114