

The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

Bureau of Health Professions Licensure

*Board of Registration in Pharmacy* *239 Causeway Street, Suite 500, 5th Floor Boston, MA 02114*

[www.mass.gov/dph/boards/pharmacy](http://www.mass.gov/dph/boards/pharmacy)

*PH (617)973-0960 ~ FAX (617)973-0980 ~ TTY (617)973-0895*

**Continuing Education Submission Form**

This completed form and supporting documentation must be submitted to the Board for review at least **30 days in advance** of the scheduled program date. A *separate* form for each continuing education program for which you seek approval must be submitted. Before submission, please review requirements at 247 CMR 4.05: <http://www.mass.gov/courts/docs/lawlib/230-249cmr/247cmr4.pdf>

**Please submit the following information to:** **RequestRxBOPCE@MassMail.State.MA.US**

* **Completed submission form**
* **Objectives and detailed outline / copy of the presentation**
* **Certificate of completion template** to include**:** name of the program, name of participant, date completed, number of credits, Board approval number, program location, and authorized signature (i.e. CE program coordinator, presenter)
* **Evaluation template or method**: to evaluate faculty, learning experiences, instructional methods, facilities, educational resources, and attainment of objectives
* **Curriculum vitae (CV) or résumé for *each* presenter**

**NOTE**: After the program, the provider must forward a copy of the **attendance list, complete with program number**, to the email address above. The provider will be directly responsible to the Board for verification of participation for no less than 3 years with the name of each participant and program number.

Presenter Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Delivery Mode: \_\_\_\_ Live Program \_\_\_\_ Home Study \_\_\_\_ Other (describe)

Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuition/Fee (if any): $ Length of Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes

 (60 minutes = 1 contact hour)

Advisor/Preceptor/Site Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Board Staff use only:**

Program Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount of Credit: \_\_\_\_\_\_\_\_\_\_\_contact hour(s)

Category approval (if any):

* Complex Non Sterile Compounding  Sterile Compounding
* Immunization  Law