



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)

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## 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](mailto: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: \_\_\_\_\_

### Board Staff use only:

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

Category approval (if any):

- |  |  |
|--|--|
| <input type="checkbox"/> Complex Non Sterile Compounding | <input type="checkbox"/> Sterile Compounding |
| <input type="checkbox"/> Immunization                    | <input type="checkbox"/> Law                 |