SPCB Employer Verification Form

Please print clearly and neatly. All sections of the form must be completed. Incomplete or illegible applications will not be processed. Please submit a separate form for each employer. ***Self-employed pharmacists please refer to Section C***.

SECTION A. To be Completed by Applicant

APPLICANT INFORMATION

Last Name | First Name | Middle Initial

Phone | Email

EMPLOYER OR MANAGER INFORMATION

Supervisor Last Name | Supervisor First Name

Job Title(s)

Company Name

Address

City | State | Zip

Phone | Email

By my signature below I grant permission to the company listed above to release to the Specialty Pharmacy Certification Board (SPCB) the information requested on this form for the purposes of verifying my employment and Specialty Pharmacy practice hours. I also attest that all information provided on this form is accurate and truthful and I acknowledge that failure to submit complete or accurate information may result in disciplinary action including the suspension or revocation of CSP certification.

Applicant Signature | Date

SECTION B. To be Completed by Employer

Applicants for Certified Specialty Pharmacist (CSP) certification are required to document at least 3,000 hours of Specialty Pharmacy practice during the four years prior to applying for certification.

I attest that the certification candidate identified in Section A above has completed _____ hours of specialty pharmacy practice during the four year period prior to the date on this form. I further attest that I am authorized by the company listed above to provide the information and verification included on this form.

Employer / Manager Signature | Date

SECTION C. Self-Employed Pharmacists

Self-employed specialty pharmacists should complete both section A and section B of this form. Section C should be completed by an individual knowledgeable about the pharmacist's practice.

Last Name | First Name

Address

City | State | Zip

Phone | Email

I attest that the certification candidate identified in Section A above has completed _____ hours of specialty pharmacy practice during the four year period prior to the date on this form.

Signature

Date