

**DIVISION OF MEDICAL QUALITY ASSURANCE  
BOARD OF PHARMACY  
4052 BALD CYPRESS WAY, BIN #C-04  
TALLAHASSEE, FLORIDA 32399-3254  
(850) 245-4292**



**IMMUNIZATION ADMINISTRATION CERTIFICATION  
APPLICATION AND INFORMATION**

**JANUARY 2011**



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Dear Florida Immunization Administration Certification Applicant:

Thank you for applying for certification to administer immunizations in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the board) staff to process your application as soon as possible.

*Florida Statutes* require a completed application and fees before your application can be reviewed. You should use the enclosed checklist to ensure that all sections of the application are complete and that the required forms are submitted. Please read these instructions carefully and fully before submitting the application. You should keep a copy of the completed application and all other materials sent to the board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the board staff, you are encouraged to email the board staff at [mqa\\_pharmacy@doh.state.fl.us](mailto:mqa_pharmacy@doh.state.fl.us), or you may call us at (850) 245-4292. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Board of Pharmacy

## General Information

### **Requirements for Immunization Administration Certification:**

To become certified to administer immunizations, an applicant must meet the following requirements.

- 1) Must hold a Florida pharmacist license that is active and in good standing.
- 2) Must successfully complete an immunization administration certification program of no fewer than 20 hours, approved by the Florida Board of Pharmacy.
- 3) Must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of influenza virus immunizations by the pharmacist. The written protocol shall include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer influenza virus immunizations. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for immunization. Supervising physicians shall review the administration of influenza virus immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician.
- 4) Must maintain at least \$200,000 of professional liability insurance.
- 5) Must obtain written permission from the pharmacy owner, if the applicant is to administer immunizations while acting as an employee of a pharmacy.
- 6) Once certified, must report immunizations administered to the state registry of immunization information, Florida SHOTS. If a pharmacist is planning to administer immunizations outside a pharmacy practice setting, the pharmacist must register with Florida SHOTS as an individual. If a pharmacist is administering immunizations as an employee of a pharmacy, the pharmacy practice location (permittee) must designate one pharmacist certified to administer immunizations to register and be responsible for maintenance of the pharmacy's Florida SHOTS account. Please check with your pharmacy's Prescription Department Manager to determine who will submit this information for your pharmacy. A Florida SHOTS application is attached for your convenience.

For information on how to batch upload this data, please visit the Florida SHOTS website at <http://www.flshots.com/resources/data.html>.

## **Application Processing**

**Please read all application instructions before completing your application.**

Within 30 days of receipt of your application and fees, the board office will notify you of the receipt of your application, any required documents, and your status. If your application is complete, you will be issued a license within 30 days. If your application is incomplete, you will be notified in writing of the missing documents required to complete your application.

## **APPLICATION REQUIREMENTS FOR IMMUNIZATION ADMINISTRATION CERTIFICATION**

**Please submit the following to the Florida Board of Pharmacy:  
P.O. Box 6320, Tallahassee, FL 32314-6320**

**ITEM #1 – Immunization Administration Certification Application:** All sections must be completed in full. Failure to submit a complete application will result in a processing delay. If you provide false information, the board *may* deny your application for certification. **Please attach a check payable to THE FLORIDA DEPARTMENT OF HEALTH in the amount of \$55.00.**

**Immunization Administration Certification Program:** Applicants must successfully complete an immunization administration certification program of no fewer than 20 hours, approved by the Florida Board of Pharmacy.

**Protocol:** Applicants must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of influenza virus immunizations by the pharmacist. The written protocol shall include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer influenza virus immunizations. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for immunization. Supervising physicians shall review the administration of influenza virus immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician. The protocol must contain the signature of the pharmacist and the physician.

A pharmacist may not enter into a protocol that is to be performed while acting as employee without the written approval of the owner of the pharmacy.

**Professional Liability Insurance:** Upon becoming certified, applicants must maintain at least \$200,000 of professional liability insurance.

**CPR –Submit a copy of your current Certified Pulmonary Resuscitation Card**

### **Florida SHOTS Registration**

**Pharmacists certified to administer influenza virus immunizations are responsible for reporting electronic immunization data to Florida SHOTS, as required by *Florida Statutes*.**

Each practice location (pharmacy permittee) where immunizations will be administered must designate one person to register with the Florida SHOTS program as described below. Please contact your Prescription Department Manager to determine who will submit data to the immunization registry for your pharmacy.

The registered pharmacist is responsible for reporting data to the immunization registry as required by statute, and must ensure staff adherence to confidentiality and information security, management of system accounts (including immediate termination of accounts for staff no longer employed), and maintenance of new user identification and temporary password assignment.

Pharmacists administer immunizations outside the pharmacy practice setting must register with Florida SHOTS as an individual.

Please follow the directions below to register for access to Florida SHOTS.

1. Obtain a DH 1997 Form (*Authorized Licensed Pharmacist User Agreement for Access to Florida SHOTS (Florida State Health Online Tracking System)*) from [www.flshots.com](http://www.flshots.com).
2. Complete the form and mail or fax to the address indicated on the form. Be sure to include the pharmacy permit number as well as the applicant's pharmacist license number. Also, be sure to provide the requested information regarding the immunization administration certification program.
3. Once the application form is received by the Florida SHOTS enrollment staff, a valid license check is conducted to ensure credentials are in place and in good standing.
4. Florida SHOTS enrollment desk staff will contact you with information about access to Web-based training for Florida SHOTS users.
5. Once web-based training for Florida SHOTS users is complete, an organization account is established for the permitted pharmacy and the pharmacist applicant is provided with a user ID and temporary password.
6. The authorized pharmacist applicant may add others to the organization account using their enrollment credentials. Adding others is subject to pharmacy policies regarding background checks and access to confidential data.
7. Accounts must be maintained by the registered pharmacist for each practice location (permit). When authorized users terminate from an organization, their access to Florida SHOTS must be terminated by the registered pharmacist immediately. Florida SHOTS includes an automated password reset that allows authorized users to maintain passwords.
8. Call the Florida SHOTS Enrollment Desk at 1(877) 888-SHOT (7468) with any questions regarding the status of your enrollment or account.

For information on how to batch upload this data, please visit the Florida SHOTS website at <http://www.flshots.com/resources/data.html>.

DH MQA 1125, 02/10,  
Rule 64B16-26.1032, F.A.C

## APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation to the board, will result in an incomplete application. **Final approval cannot be granted until the application is complete.** Faxed applications will not be accepted.

\_\_\_\_\_ **Immunization Administration Certification Application (Item #1)**

\_\_\_\_\_ **Check made payable to the FLORIDA DEPARTMENT OF HEALTH in the amount of \$55.00.**

\_\_\_\_\_ **Immunization Certification Program** – All applicants must complete an immunization administration certification course prior to board certification. The course shall be no less than twenty (20) contact hours, shall be board approved, and shall cover the subjects listed in subsection 64B16-26.1031, F.A.C. Please refer to CE Broker's website at [www.CEBroker.com](http://www.CEBroker.com) for a list of approved providers. **(Submit a copy of the course completion certificate to the Board of Pharmacy).**

\_\_\_\_\_ **Protocol** – All applicants must enter into a protocol under a supervisory practitioner who is a physician licensed under chapter 458 or chapter 459, F.S. Each protocol must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of influenza virus immunizations by the pharmacist. The written protocol shall include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer influenza virus immunizations. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for immunization. Supervising physicians shall review the administration of influenza virus immunizations by the pharmacists under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician. A pharmacist may not enter into a protocol that is to be performed while acting as employee without the written approval of the owner of the pharmacy. **(Submit a copy of the protocol between the applicant and practitioner.)**

\_\_\_\_\_ **Professional Liability Insurance** – All applicants must maintain at least \$200,000 of professional liability insurance. **(Submit a copy of the professional liability insurance policy to the Board of Pharmacy. NOTE: If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company letterhead verifying that you are covered under their company policy.)**

\_\_\_\_\_ **CPR** –Submit a copy of your current Certified Pulmonary Resuscitation Card

## **BIOMEDICAL WASTE PERMIT**

Each pharmacy must obtain a biomedical waste permit from the Department of Health because the facility is generating biomedical waste when providing flu shots. The objective of the biomedical waste program is to protect health care workers, environmental-service staff, waste haulers, and the general public from risks associated with potentially infectious biomedical waste. The biomedical waste website is <http://www.myfloridaeh.com/community/biomedical/index.html>.

Please review the statute governing this permit <http://www.flsenate.gov/Laws/Statutes/2010/381.0098>



**FLORIDA BOARD OF PHARMACY**  
 P.O. Box 6320 • Tallahassee, FL 32314-6320  
 Phone: (850) 245-4292 www.doh.state.fl.us/mqa/pharmacy

**ITEM #1 – IMMUNIZATION ADMINISTRATION CERTIFICATION APPLICATION**  
**FEE: \$55.00**

Please print or type legibly.

<b>1. Biographical Data</b>						
<b>Last Name</b>		<b>First Name</b>		<b>Middle Name</b>		
<b>Mailing Address</b>			<b>City</b>		<b>State</b>	<b>Zip</b>
<b>Home Phone Number</b>		<b>Business Phone Number</b>		<b>E-Mail Address</b>		
<b>2. Equal Opportunity Data</b> – We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43FR38295 (August 25, 1978). The information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.						
SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female						
RACE: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other						
<b>3. Do you have a Florida Pharmacist (PS) license active and in good standing? If yes, what is the license number? You must hold a Florida pharmacist license that is active and in good standing.</b>						
Yes _____		No _____		Florida License Number: PS_____		
<b>4. Have you ever held an immunization administration certification in Florida? If yes, what was the certification number?</b>						
Yes _____		No _____		Florida Certification Number: _____		
<b>5. Immunization Administration Certification Program</b> - Have you successfully completed a Florida Board of Pharmacy approved immunization administration certification program? If yes, please provide the provider name, provider number, date of completion, and certificate number. Please attach a copy of the certificate of completion to this application.						
Yes _____		No _____				
<b>Provider Name</b>		<b>Provider Number</b>		<b>Date of Completion</b>		<b>Certificate Number</b>
<b>6. Protocol Information</b> – Please provide the name, license number, address, and contact telephone number of the physician licensed under chapter 458 or 459, <i>Florida Statutes</i> , with whom you have entered into a protocol. Please attach a copy of the protocol to this application.						
<b>Physician Name</b>			<b>Physician License Number</b>		<b>Contact Telephone Number</b>	
<b>Mailing Address</b>						
<b>City</b>		<b>State</b>			<b>Zip Code</b>	

<b>7. Do you intend to administer immunizations while acting as the employee of a pharmacy?</b>			
Yes _____ No _____			
<b>8. Please provide the following information for the pharmacy where you are employed and intend to administer immunizations.</b>			
<b>Pharmacy Name</b>		<b>Pharmacy Permit Number</b>	<b>Pharmacy Telephone Number</b>
<b>Street Address</b>		<b>City</b>	<b>State</b>
			<b>Zip Code</b>
<b>Prescription Department Manager Name</b>		<b>License Number</b>	<b>Contact Telephone Number</b>
<b>9. Are you the designated Florida SHOTS registrant for your pharmacy or do you plan to administer immunizations outside a pharmacy practice location?</b>			
Yes _____ No _____			
If yes, please complete the enclosed Florida SHOTS user agreement and submit it to the Department of Health Bureau of Immunization at the address provided on the form and skip question 10. If no, please answer question 10.			
<b>10. If you are not the designated Florida SHOTS registrant, please provide the designated registrant's information below. (NOTE: If your corporate office uploads this data, please write "Headquarters" under "pharmacist name.")</b>			
<b>Pharmacist Name</b>		<b>License Number</b>	<b>Contact Telephone Number</b>
<b>11. Professional Practice Insurance – Do you maintain at least \$200,000 of professional liability insurance? If yes, please provide your insurance provider name, policy number, and policy expiration date. Please attach a copy of the policy to this application. (NOTE: If your employer provides blanket professional liability insurance coverage for all employees, please attach a copy of the policy or a letter on company letterhead verifying that you are covered under their company policy.)</b>			
Yes _____ No _____			
<b>Insurance Provider Name</b>		<b>Policy Number</b>	<b>Policy Expiration Date</b>
The information contained herein is true and correct to the best of my knowledge, and am aware that my immunization administration certification may be suspended or revoked if I violate any pharmacy law, rule or regulation, and the Florida Board of Pharmacy Code of Conduct, and hereby affix my signature as acknowledgement and agreement of such terms.			
_____		_____	
Applicant Signature		Date	



**Authorized Licensed Pharmacist  
User Agreement  
For Access to Florida SHOTS  
(Florida State Health Online Tracking System)**



Florida SHOTS is the centralized electronic state immunization registry for recording and tracking immunizations as authorized by s. 381.003, F.S.

➤ *Completion of this agreement according to the following conditions and instructions is required for authorized access to Florida SHOTS. Pursuant to section 465.189(4), F.S., licensed pharmacists certified by the Florida Board of Pharmacy to administer influenza vaccinations to adults must report such vaccinations to the state immunization registry (Florida SHOTS). Please follow the instructions below in order to access Florida SHOTS for reporting purposes.*

**TERMS OF AGREEMENT**

**PLEASE READ CAREFULLY. As a CONDITION for enrolling in the Florida State Health Online Tracking System, the LICENSED PHARMACIST (licensed pursuant to s. 465.007, F.S.) identified on this application for enrollment and certified to provide adult influenza virus immunizations AGREES TO:**

1. Use the database to register and record immunization information for patients currently receiving immunizations under their care.
2. Enter accurate and current data in Florida SHOTS at the time of immunization administration.
3. Accept and abide by all relevant state statutes concerning medical record confidentiality and Florida SHOTS access.
4. Ensure pharmacy staff accessing Florida SHOTS, as authorized by the licensed pharmacist applicant, adheres to all laws and regulations pertaining to use and access.
5. Maintain user accounts such that only current authorized users have access to Florida SHOTS and all terminated staff are appropriately removed from access.
6. Safeguard user IDs and passwords against unauthorized use and assume responsibility for staff access to Florida SHOTS.
7. Notify Florida SHOTS personnel immediately upon revocation or suspension of license.

***In addition, for all authorized users of Florida SHOTS, it is UNDERSTOOD that:***

1. Authorized users may assign staff access to Florida SHOTS and are solely responsible for managing such access.
2. The authorized licensed pharmacist agrees to be solely liable and hold the Department of Health harmless for any breaches of confidentiality by the pharmacist or the pharmacist's staff.
3. Access to Florida SHOTS will be terminated immediately upon license revocation or suspension, or for breaches of confidentiality or failure to adhere to any portion of this agreement.

**Complete and sign the attached form according to the following instructions:**

**INSTRUCTIONS:**

**REVIEW SECTION I AND FILL OUT SECTION II ACCORDING TO THE FOLLOWING INSTRUCTIONS:**

1. Provide the pharmacy facility name, address, city, zip, phone, fax, pharmacy permit number and county where pharmacy is located.
2. Provide the information for the pharmacist applicant. The pharmacist whose name appears on this enrollment application will be responsible for granting Florida SHOTS access to other authorized pharmacy staff and will receive a user ID and password to access Florida SHOTS.
3. The pharmacist must sign the agreement in the space provided. By signing the agreement, the pharmacist agrees to ensure that staff accessing Florida SHOTS under his or her authorization will adhere to the same laws and regulations pertaining to access and maintenance of confidential information.

**SECTION III – Agreement Submission** - Mail or fax this form to the address or fax number indicated. If you have any questions regarding completion of the form or about Florida SHOTS, please call the telephone number provided.

