



CANNON BUILDING
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STATE OF DELAWARE
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

REQUEST FOR APPROVAL AS A CONTINUING EDUCATION PROVIDER

INSTRUCTIONS

When to Submit

If you are a continuing education (CE) provider **located in Delaware**, submit this form to request Board approval as a provider, which will enable Delaware licensees to obtain CE credit for your programs/courses.

- If you are a CE provider that is **not** located in Delaware, do **not** submit this form. Delaware licensees may receive credit for your programs/courses only if you are approved by the Accreditation Council for Pharmacy Education (ACPE).
- If you are a Delaware-licensed Pharmacist, do **not** submit this form. To request approval of CE courses/programs you plan to take (or have taken), see the [Request for Individual Program Approval](#) form.

For full details on CE requirements, see Section 1.5 of the Board's [Rules and Regulations](#).

Documentation Required

- Submit completed, signed request form.
- Enclose fee of \$40 by check or money order payable to "State of Delaware."**
- Enclose a sample document that participants will receive to prove successful completion of CE programs. The document must meet the criteria outlined in the Section 1.5.4.1.5.2.5 of the Board's [Rules and Regulations](#).
- Enclose your written policy concerning grievances and tuition.
- If accredited by another agency, enclose documentation of accreditation.
- Enclose a list of any programs given in the past 12 months. Include a description of each program, length (excluding breaks, meals, social activities and administrative time), dates, presenters' names, number and profession of attendees).

REQUESTER COMPLETES THIS SECTION

1. Provider Name: _____
Address: _____
Street City State Zip code
Phone: _____ Other: _____ Email: _____ @ _____
2. Check one: Institution School Professional Society Other: _____
3. Name and title of the person who will administer CE programs: _____
4. Is this provider accredited by any other agency, such as another Board of Pharmacy? Yes No **If yes, enclose documentation of accreditation.**
5. What is the overall objective of your programs? _____

6. Describe how you plan and develop individual programs: _____

7. Check the types of educational programs that will be offered: (check all that apply)
 Lecture (check one):
 Live lecture only Live lecture with open discussion period Live lecture with discussion or workshop groups
 Other lecture (e.g., distance learning): _____
 Workshop or discussion groups only
 Laboratory
 Journal articles
 Home study
 Presentation of scholarly articles or research
 Other: _____

REQUESTER COMPLETES THIS SECTION (continued)

8. Describe equipment and teaching aids used: _____

9. What standards will you use to select presenters? _____

10. Have you provided any CE programs in the last 12 months? Yes No **If yes, attach a list of programs given. Include a description of each program, length of each program (excluding breaks, meals, social activities and administrative time), program dates, presenters' names, number and profession of attendees).**
11. Describe how you evaluate the effectiveness of your programs: _____

12. How often will you update programming? _____
13. Check the method(s) that you will use to assess attendees achievement for credit to be awarded:
 Pre-Test and Post-Test for programs three or more hours long
 Post-Test for programs one to two hours long
 Evaluation
- Note:** If pre- and post-test requirements are not met, 25% of the requested number of CE hours will be deducted.
14. How will you determine if CE credit will be awarded to a participant? _____

Enclose a sample document that participants will receive to prove successful completion of CE programs. The document must meet the criteria outlined in the Section 1.5.4.1.5.2.5 of the Board's [Rules and Regulations](#).

15. How will you maintain records of CE participation? _____
Enclose your written policy on grievances and tuition.
16. Do you understand that you must allow authorized agents of the Board to examine any records or other materials pertaining CE activities without notice during normal business hours. Yes No
17. Do you understand that you must allow an authorized agent of the Board to conduct monitor your CE programs onsite without charge (i.e., registration fees will be waived)? Yes No

I certify that all the facts stated in this request, including the statements in enclosed documents, are true, complete and correct. I agree to abide with the laws of Delaware and the federal government.

Signature: _____ **Date:** _____
Person Responsible for CE Program

Printed Name: _____ Title: _____

Submit this form, fee and all supporting documentation to the Delaware Board of Pharmacy at the address above. If you have questions, email: customerservice.dpr@state.de.us.

BOARD OFFICE COMPLETES THIS SECTION

Board Review Date: _____ Executive Secretary Signature: _____

- Approved for _____ hours. Approval Expires: _____
- Tabled - List reason(s) below. Denied – List reason(s) below.

The above request was denied or tabled for the following reason(s):
