West Virginia Board of Pharmacy
2310 Kanawha Blvd. East, Charleston, WV 25311
Phone: 304-558-0558 Fax: 304-558-0572

Application for Continuing Pharmacy Education Credit

One CE request per application. Incomplete applications will be returned.

NOTE: Application only required for general CE programs not already approved by ACPE or for programs submitted to meet drug diversion or consulting practice CE requirement.

- All applications must be received by the end of each month.
- Applicants will be notified by the last Monday of each month if the program was approved, denied or if additional information is required**.**
- **If approved, continuing education (CE) certificates issued to participants must list:**
  - **Title of the program**
  - **Number of CE hours awarded**
  - **WV Board of Pharmacy Program Number**
  - **Signature of program administrator**
  - **Date signed**
- A record of the participant's attendance and copy of the CE certificate must be maintained for a period of 4 years from the program's date
- ***With a committee-approved CE request it is the responsibility of the provider to supply the approval code submitted by the West Virginia Board of Pharmacy to the attendees.***

PROVIDER/RPH INFORMATION:

Date of submission: _____ Applicant (**check one**): CE Provider _____ Pharmacist _____

Name of CE Provider/Pharmacist: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Cell Phone: _____ Work Phone: _____ Fax: _____

Contact Person (if CE Provider): _____ Phone Number: _____

PROVIDER INFORMATION: Applications submitted without proper and complete documentation will be returned and not considered by the committee. The following 3 items must be submitted with each application:

Check list:

1. **Agenda** with times of events _____
2. List of all **faculty and brief bio sketch** for each faculty member _____
3. **Learning objectives** for each session (List the session title followed by at least 3 learning objectives. Each objective should start with a behavioral verb such as describe, list, state and others.

Additional sheets may be attached if needed). _____

Date of Program: _____ Title of Program: _____

Location (Facility, City and State): _____

Number of CE hours requested: _____

NOTE: ***The determination of CE credits is at the discretion of the CE committee and may be less than the amount requested.***

Type of CE credit requested: (check one): Consulting _____ General _____ Live _____

Drug Diversion Training and Best Practice Prescribing of Controlled Substances _____