CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

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

REQUEST FOR REGISTRATION AS A CERTIFIED PHARMACY TECHNICIAN TO ADMINISTER THE COVID-19 VACCINE

This form is to be completed by pharmacy technicians certified by either the Pharmacy Technician Certification Board or the National HealthCareer Association who are requesting to administer the COVID-19 vaccination under the supervision of a Delaware-licensed pharmacist.

CERTIFIED PHARMACY TECHNICIAN INFORMATION

1. Full Name:_____
   Last First Middle
2. Mailing Address:_____
   City State Zip
3. Phone Number:_____
   Home Cell Work
4. Email:_____

CERTIFICATION INFORMATION

The certified pharmacy technician requesting registration is required to have certification from either the Pharmacy Technician Certification Board or the National Healthcareer Association.

1. Certification Organization:_____
2. Certification Organization's Address and Phone Number:

   _____
3. Date of Certification:_____
4. Certification Number:_____

Attach Proof of Certification.

PRACTICAL TRAINING INFORMATION

The certified pharmacy technician requesting registration is required to complete practical training through a program approved by the Accreditation Council for Pharmacy Education ("ACPE") and such program must include hands-on injection technique and the recognition and treatment of emergency reactions to vaccines.

1. Name of Program: _____

2. Program's Address and Phone Number:

   _____

3. ACPE Approval Number: _____

4. Date of Completion: _____

Attach Proof of Completion of Practical Training.

CPR CERTIFICATION INFORMATION

1. Name of CPR Certification Organization: _____

2. Organization's Address and Phone Number: _____

Attach Copy of Current CPR Card.

EMPLOYER INFORMATION

1. Employer: _____

2. Employer's Address: _____

3. Employer's Contact Name and Phone Number: _____

SUPERVISING PHARMACIST INFORMATION

The certified pharmacy technician must be supervised by a Delaware-licensed pharmacist who must be **at all times readily and immediately available** to the immunizing technician.

1. Full Name: _____
   Last First Middle

2. Mailing Address: _____
   City State Zip

3. Phone Number: _____
   Home Cell Work

4. Email: _____

5. License Number: _____

6. Supervisor's Employer's Name and Address:

   _____

CERTIFICATION – CERTIFIED PHARMACY TECHNICIAN

I declare and affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge and that I will comply with the requirements set forth herein.

Signature:_____ **DATE:** _____

CERTIFICATION – SUPERVISING PHARMACIST

I declare and affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge and that I will comply with the requirements set forth herein.

Signature:_____ **DATE:** _____

Return the completed form to the Division of Professional Regulation, 861 Silver Lake Boulevard, Suite 203, Dover, DE 19904, customerservice.dpr@delaware.gov or fax 1-302-739-2711.