



APPLICANT ATTESTATION LETTER FOR THE USPHS NATIONAL CLINICAL PHARMACY SPECIALIST CERTIFICATION

Applicant Name: _____

Collaborating Physician or Clinic Coordinator Name: _____

Facility Name: _____

Position/Title: _____

Email Address: _____ Telephone Number: _____

Please check the boxes below box only if the applicant has met the requirement(s).

Check	Requirement
☐	The pharmacist listed above has completed at least two years at any public health facility (IHS, ICE, BOP, CG, DoD, VA), six (6) months of which he/she has been practicing as an advanced practice pharmacist at the local facility.
☐	The applicant listed above is currently practicing as an advanced practice pharmacist at the public health facility in the areas of practice authority in which he/she is requesting certification.
☐	The applicant listed above possesses a nationally recognized certification salient to the clinical practice in which NCPS certification is being requested, OR equivalent clinical experience, OR has completed an ASHP-accredited postgraduate residency, OR possesses a current state-issued pharmacist clinician/practitioner's license.
☐	The applicant listed above has documented forty-five (45) outpatient encounters or inpatient clinical interventions within the past 12 months, covering the areas in which certification is requested, confirmed by a NCPS provider or collaborating physician. Review and evaluation of the charts must demonstrate the pharmacist's ability to appropriately monitor the patient, order and interpret laboratory tests, perform limited physical assessment, prescribe medications, provide patient education, appropriate follow-up, outcomes data, and referral of the patient to another provider when necessary. The documentation is kept on file at the local facility.
☐	The applicant listed above has obtained fifteen (15) hours of clinically pertinent CE within the last year OR has obtained an equivalent number of documented contact hours with a medical staff provider.
☐	The local facility has performed and documented initial and annual competency reviews on the applicant listed above. The documentation is kept on file locally.

By signing below, I attest that the NCPS applicant referenced above has met the requirements listed above for NCPS certification.

Signature of the collaborating physician or clinic coordinator

Date

RESET FORM