



APPLICANT ATTESTATION LETTER FOR THE USPHS NATIONAL CLINICAL PHARMACY SPECIALIST-DIAGNOSTIC CERTIFICATION

Applicant Name: _____

Facility Name: _____

Position/Title: _____

Collaborating Physician Name: _____

Supv. Chief Pharmacist or Reg. Chief Pharmacist Name: _____

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 a advanced practice pharmacist at the public health facility under a collaborative practice agreement or with individual privileges under a comprehensive protocol.
☐	The applicant listed above has documented five hundred (500) outpatient encounters providing comprehensive care within the past 24 months, which have been reviewed and confirmed by a supervising pharmacist and/or collaborating physician. Review and evaluation of the charts has demonstrated and confirmed the applicant's ability to appropriately formulate a diagnosis, monitor the patient, order and interpret laboratory tests, perform appropriate physical assessment, prescribe medications, and provide patient education, appropriate follow-up, and referral of the patient to another provider when necessary, and maintain outcomes data. All encounters documented on the attached template are accurately represented.
☐	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

Date

Signature of the pharmacy director/supervising chief pharmacist
or regional chief pharmacist

Date

RESET FORM