Kentucky Board of Pharmacy
Continuing Education Program Approval Form

State Office Building Annex, Suite 300
125 Holmes Street
Frankfort, KY 40601
Phone 502-564-7910 Fax 502-696-3806

□ Group Request or □ Individual Request Date _____
□ Attendance at Program
□ Presentation of Program

Title/Topic_____

Name of the Provider/Sponser
_____

Address _____

_____

E-mail Address_____

Name of Individual / Group Submitting for Approval _____

Address _____

Business Phone_____ E-mail Address_____

Brief Summary or Objectives of Program - Enclose Brochure [if available].
_____
_____
_____
_____

Faculty / Presenters - (Name and Qualifications)
_____
_____
_____
_____

Program Dates _____ CEU(s) _____ Contact Hours _____ Kentucky Site _____

Mode / Method of Presentation:

Live Presentation _____ (Minutes) Video _____ (Minutes) Discussion _____ (Minutes) Other _____ (Specify) (Minutes)

FOR OFFICE USE ONLY

Approved _____ **Disapproved** _____ **CEU(s) Awarded**_____ **ID No.** _____

_____ *Date*

_____ *Pharmacy Education Coordinator*