FOR OFFICE USE
□ Approved □ Denied

Date _____

Initials _____

State Office Building Annex
125 Holmes Street, Ste 300
Frankfort, KY 40601
Phone 502-564-7910 Fax 502-696-3806
pharmacy.board@ky.gov

APPLICATION FOR PHARMACIST CE APPROVAL

No program will be approved past 30 days of program presentation. Form and supplemental documentation may be mailed, emailed or faxed. Illegible or incomplete submissions will be returned. The board reserves the right to deny approval of any request. The request should be free commercial bias.

Application Date Submitted _____

For each individual program, please complete the following:

Presentation Date[s] _____

Pharmacist name _____
Address _____
Phone Number _____
License Number _____ NABP e-Profile ID _____

Name of Provider/Sponsor/Organization/Institution

_____
Address _____
Phone Number _____
Email address of Provider/Sponsor _____

Presenters/CE Coordinators name _____
Presenter's credentials/title. _____

Name of Continuing Education _____
Number of credit hours being requested _____
List of CE Goals and Objectives (use additional paper if necessary)

_____
_____
_____
_____

Please include a copy of the power point or a complete handout of the desired program.