Louisiana Board of Pharmacy

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Application for Collaborative Drug Therapy Management (CDTM) Registration

Note: Incomplete applications shall be returned to the applicant unprocessed. Affirmative replies to Items 4, 5, 6, or 7 in Section 3 shall be supplemented with explanatory statements signed by the applicant

Section 1. Pharmacist Information

Name ____ Pharmacist License No. _________________

Mailing Address ____

Telephone No. ____________________ Email Address ____

Professional Degrees & Certifications____

Section 2. CDTM Practice Profile

Nature of Medical Condition(s) Under Management ____

Collaborating Physician(s) ____

Practice Site(s) ____

Section 3. Certifications

1. Yes ☐ No ☐ I am actively engaged in the practice of pharmacy in Louisiana and the provision of pharmacist care similar to the activities anticipated in the collaborative drug therapy management protocol(s).

2. Yes ☐ No ☐ I have read the Board's rules on Collaborative Drug Therapy Management as published on the Board's website (LAC 46:LIII.523).

3. Yes ☐ No ☐ I possess a current and unrestricted license to practice pharmacy in Louisiana, and I am not the subject of a pending investigation or complaint by the Board or by the pharmacy licensing authority of any other state or jurisdiction.

4. Yes ☐ No ☐ At any time in the past, I have voluntarily surrendered my pharmacist license, or my license has been revoked, suspended, placed on probation, or restricted in any manner, either by the Board or by the pharmacy licensing authority of any other state or jurisdiction.

5. Yes ☐ No ☐ At any time in the past, I have voluntarily surrendered a controlled dangerous substance (CDS) license or Drug Enforcement Administration (DEA) registration, or my CDS license or DEA registration has been revoked, suspended, placed on probation, or restricted in any manner, either by the Board or by the DEA or by the pharmacy licensing authority of any other state or jurisdiction.

6. Yes ☐ No ☐ At any time in the past, I have had an application for pharmacist licensure rejected or denied, either by the Board or by the pharmacy licensing authority of any other state or jurisdiction, or such application or license is currently in the process of being rejected, denied, terminated, revoked, suspended, placed on probation, or restricted in any manner, either by the Board or by the pharmacy licensing authority of any other state or jurisdiction.

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Section 3. Certifications (cont.)

7. Yes ☐ No ☐ At any time in the past, I have been (or I am now in the process of being) denied, terminated, suspended, refused, limited, placed on probation or under any other disciplinary action with respect to participation in any private, state, or federal health insurance program.

8. Yes ☐ No ☐ I acknowledge that in signing this application, I am certifying as to the authenticity and veracity of all information being provided.

Section 4. Signature

Signature of Applicant (no stamps) ____ Date _____________

FOR BOARD USE ONLY
Approved by ____
Date _______________________________ CDTM Registration No. ____________________