



Louisiana Board of Pharmacy

5615 Corporate Boulevard, 8th Floor
Baton Rouge, Louisiana 70808-2537
www.labp.com



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 2 shall be supplemented with explanatory statements signed by the applicant. Since an original signature is required, you must either mail or hand-deliver your signed application. We will not process faxed documents.

Section 1. Pharmacist Information

Name _____ Pharmacist License No. _____

Mailing Address _____

Telephone No. _____ Email Address _____

Professional Degrees & Certifications _____

Section 2. Certifications

1. 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.
2. 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 agreement.
3. 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).
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 Yes No At any time in the past, I have voluntarily surrendered my pharmacist license, or my license has been revoked, suspended, placed on probation, or restricted in any manner, either by the Board or by the pharmacy licensing authority of any other state or jurisdiction.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(CDS) license or Drug Enforcement Administration (DEA) registration, or my CDS license or DEA registration has been revoked, suspended, placed on probation, or restricted in any manner, either by the Board or by the DEA or by the pharmacy licensing authority of any other state or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.
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 3. Signature

Signature of Applicant (no stamps) _____ Date _____

FOR BOARD USE ONLY

Approved by _____

Date _____ CDTM Registry No. _____