



APPLICATION FOR THE USPHS
NATIONAL CLINICAL PHARMACY SPECIALIST RECERTIFICATION



COVER LETTER

Thank you for your interest in recertifying as a National Clinical Pharmacy Specialist (NCPS). To maintain NCPS certification, a pharmacist must recertify every three years. Many aspects of NCPS certification have changed since August 2017. If this is your first time recertifying, you will need to review the changes and determine if you are eligible for recertification or if an initial certification application is required.

In 2016, the Chief Pharmacy Officer of the United States Public Health Service tasked the NCPS Committee to align the program with the evolving health care transformation to support clinical pharmacists with an advanced scope of practice and their role in providing a higher level of comprehensive medication and disease state management services. This can also support clinical pharmacists credentialed and privileged through their local medical staff process. As of August 2017, only pharmacists who provide comprehensive care in multiple areas (versus a single practice area) will be eligible for NCPS certification.

Each applicant must demonstrate the active provision of patient care integrated into a holistic model. NCPS certified pharmacists are currently providing primary care in hypertension, dyslipidemia, asthma, pain, hepatitis C, HIV, anticoagulation, diabetes, tobacco cessation and more. The preceding may serve as a list of potential areas for expansion, but is not intended to exclude other potential services. Ultimately, a needs assessment at the local practice site should determine areas of care in which to expand pharmacists' scope of practice. The expectation for each NCPS pharmacist is their scope of practice will continue to evolve and expand beyond these initial minimums. Any applicant who fails to demonstrate an expansion of scope of practice may not be eligible for future recertification.

Please utilize the checklist within the application on the succeeding page to ensure your application is complete. Completed applications must be received by the NCPS Committee thirty days prior to the next scheduled meeting to be considered for recertification. The NCPS Committee meets quarterly to review applications on the second Wednesday in February, May, August and November. The NCPS Committee will not act on incomplete applications.

Refer to the NCPSC website for further information: <https://dcp.psc.gov/osg/pharmacy/ncps.aspx>

★ **Completed applications should be emailed to: john.collins@ihs.gov**



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APPLICATION

DATE OF LAST CERTIFICATION: _____

DEMOGRAPHIC INFORMATION:

Legal name (as appears on license): _____

Name as desired on certificate (if different): _____

Facility Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Telephone: _____

Position: _____ Start Date: _____

PROFESSIONAL LICENSURE:

List all jurisdictions in which you currently hold a profession licensure (Attach a separate sheet if additional space is required)

Number	Specialty	State	Expires	Active (Y/N)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please complete and attach the following items:

ITEM/DOCUMENTATION	INCLUDED		COMMENTS
	YES	NO	
Copy of current pharmacy license(s)			
Local facility's collaborative practice agreement (CPA) and/or protocol.			
Critical Elements checklist *CPA/protocol must include <u>ALL</u> elements*			
Letter of Attestation			
Patient encounter log for encounters in the past 12 months from application submission			
Evidence of 45 hours of clinical pertinent CE from the previous 3 years			
Documentation of being Credentialed and Privileged through local medical staff (beginning Jan 2019). If NO, complete attached Credentialing & Privileging waiver.			
Summary of Local Advanced Practice Authority			
Clinic outcomes data for fiscal year (Oct 1 through Sept 30) in most frequent disease states managed			

I have completed all the required documentation to be considered for NCPS recertification.

Signature: _____

Date: _____



APPLICATION FOR THE USPHS
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LETTER OF ATTESTATION

APPLICANT'S NAME: _____

NCPS CLINIC COODINATOR OR COLLABORATING PHYSICIAN

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Telephone: _____

	COMPLETED	
	YES	NO
Has the applicant obtained forty-five (45) hours of clinically oriented continuing education with the past 36 months, covering areas in which recertification is requested?		
Does the application possess certifications in both tobacco cessation and immunizations?		
Is the applicant currently practicing as an advanced practice pharmacist at the public health facility in the areas of practice authority in which he/she is requesting recertification?		
Has the local facility performed and documented annual competency and peer reviews? (documentation to be kept on file locally)		

I attest the NCPS applicant referenced above has met the requirements for NCPS recertification.

Signature: _____

Date: _____



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SUMMARY OF LOCAL ADVANCED PRACTICE AUTHORITY



APPLICANT'S NAME: _____

List the areas of care in which the applicant is currently approved at the local facility to provide care therein. Submit to NCPS Committee with application and annually thereafter along with outcomes reports. Use an additional attachment if more space is needed.

Areas of Practice Authority Date Authorized Description (if not self-explanatory)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.



APPLICATION FOR THE USPHS
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CREDENTIALING AND PRIVILEGING WAIVER



APPLICANT'S NAME: _____

If you are NOT Credentialed and Privileged through your local facility's medical staff beginning January 2019, please complete the following waiver.

Department actions taken to expand adoption of credentialing and privileging pharmacists:

Barriers encountered:

Future plans for obtaining recognition as a credentialed and privileged pharmacist: