APPLICATION FOR THE USPHS NATIONAL CLINICAL PHARMACY SPECIALIST CERTIFICATION

Thank you for your interest in becoming certified as a National Clinical Pharmacy Specialist (NCPS).

Each applicant must demonstrate the active provision of comprehensive patient care. The local practice site should determine areas of care in which to expand pharmacists' scope of practice based on a needs assessment. Areas of care can include, but are not limited to, the following: acute/chronic disease management (HTN, diabetes, mental health, anticoagulation, tobacco cessation, etc.), pharmacokinetics, nutritional support, antimicrobial stewardship, dose optimization (renal, weight, indication), substance use disorder treatment, pain management, and transitions of care.

Application Deadlines: Completed applications must be received by the NCPS Committee thirty days prior to the next scheduled meeting to be considered for certification. The NCPS Committee meets quarterly to review applications on the second Wednesday in February, May, August, and November.

Please 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.

DEMOGRAPHIC INFORMATION:

Applicant Legal name (as appears on license): _____

Name as desired on certificate (if different): _____

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Email Address: _____

Position Title: _____

Dates of Affiliation/Employment: _____

PROFESSIONAL EDUCATION:

College/University Name: _____

City: _____ State: _____

Degree: _____ Date of Graduation (MM/YY): _____

College/University Name: _____

City: _____ State: _____

Degree: _____ Date of Graduation (MM/YY): _____

College/University Name: _____

City: _____ State: _____

Degree: _____ Date of Graduation (MM/YY): _____

RESIDENCIES (as applicable):

Type: _____ Institution: _____

City: _____ State: _____

Dates Attended (MM/YY-MM/YY): _____ Date of Graduation (MM/YY): _____

Type: _____ Institution: _____

City: _____ State: _____

Dates Attended (MM/YY-MM/YY): _____ Date of Graduation (MM/YY): _____

SPECIALTY & DISEASE-STATE MANAGEMENT CERTIFICATIONS & TRAININGS:

(E.g. BCPS, CDCES, Physical Assessment, DATA-Waiver, etc.). Immunization Certification is required. Use a separate sheet if additional space is needed.

	Certification Name	Date Achieved	Expiration Date (if applicable)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

PROFESSIONAL LICENSURE:

List all jurisdictions in which you currently hold professional licensure – use a separate sheet if more space is needed.

	State	License Number	Expiration Date
1.			
2.			
3.			
4.			

DEA REGISTRATION:

Please provide only if you are registered individually with the DEA to prescribe controlled substances. Do not include your facility's DEA registration number.

DEA Registration Number: _____ Expiration Date: _____

CREDENTIALING AND PRIVILEGING:

Currently credentialed and privileged through your local facility or agency's medical staff?

☐ Yes ☐ No If Yes, then include the corroborating documents in your application packet.

If No, then complete the NCPS Credentialing and Privileging Waiver Form.

AREAS OF PRACTICE AUTHORITY:

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.		

PREVIOUS PROFESSIONAL AFFILIATIONS/EMPLOYMENT:

List previous work affiliations covering the last five years.

Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Position Title: _____
Dates of Affiliation/Employment: _____

Facility Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Position Title: _____
Dates of Affiliation/Employment: _____

COLLABORATIVE PRACTICE AGREEMENT (CPA)/ PROTOCOL CRITICAL ELEMENTS CHECKLIST:

Please document in the "Notes" column which page(s) contain the required elements.

Required Elements	Notes
1. Practice procedures	
• Process for obtaining referrals and determining patient eligibility	☐ Page: _____
• Patient care procedures/protocols	☐ Page: _____
• Processes for referral to specialist provider and/or discharge back to primary care provider	☐ Page: _____
2. Comprehensive care	
• Process for managing associated comorbidities	☐ Page: _____
• Healthcare maintenance program based on local need (examples may include, but not limited to immunizations, tobacco cessation, associated screening tests, etc.)	☐ Page: _____
3. Clear statements that the pharmacist is authorized to do ALL of the following:	
• Order laboratory tests	☐ Page: _____
• Interpret laboratory tests	☐ Page: _____
• Perform limited physical assessment	☐ Page: _____
• Prescribe (initiate, modify, discontinue) medications per CPA/protocol/privileging	☐ Page: _____
• Provide and document patient education	☐ Page: _____
• Provide follow-up of the patient	☐ Page: _____
4. Training and certifications	
• Define pharmacist training requirements and other qualifications to provide direct patient care	☐ Page: _____
• Describe process for annual evaluation and documentation of competencies	☐ Page: _____
5. Outcomes	
• Identification of clinical and administrative outcome measures to be collected	☐ Page: _____
• Annually collect, document, and report outcomes to local leadership and NCPS Committee (NCPSC)	☐ Page: _____
6. Performance improvement	
• Description of continuous performance improvement or professional practice evaluation process	☐ Page: _____
• Description of peer review process	☐ Page: _____
• Report performance improvement annually	☐ Page: _____
7. Protocol approval	
• Appropriate signatures with position titles	☐ Page: _____
• Original date of approval	☐ Page: _____
• Revision or review dates	☐ Page: _____

By signing below, I attest that I have met the requirements for NCPS certification.

Applicant Signature: _____ Date: _____

APPLICATION PACKET CHECKLIST:

Please complete the below checklist and submit all required documents as part of your application packet.

ITEM/DOCUMENTATION	CHECK	EXPIRATION DATE
Copy of current pharmacist license(s) +/- DEA certificate	☐	
Evidence of 2 years at any public health facility (IHS, ICE, BOP, CG), 6 months of which applicant practiced as an advanced practice pharmacist at local facility (e.g. copy of personnel orders, OF-8, etc.)	☐	
Postgraduate education/certification(s): *At least one is required. Please submit documentation for all applicable. • Residency certificate(s) • Specialty board certification(s) • State issued Clinician's license • Disease state management certificate(s) relevant to the area(s) in which the applicant has authority to practice • Narrative (detailing experience if using clinical experience in lieu of additional certification orlicensure)		
	☐	
	☐	
	☐	
	☐	
	☐	
Clinical certifications: - Immunization Administration Certification/License (required) - Other (please list):		
	☐	
	☐	
Evidence of 15 hours of clinically pertinent CE from previous year or documentation of an equivalent number of contact hours with a medical staff provider	☐	
Copy of applicant's collaborative practice agreement(s) or facility policies or protocols demonstrating advanced pharmacy practice: • Must include comprehensive scope of practice and preventative care privileges • Appropriate signatures (Clinical Director, Chief of Pharmacy or designee) • Signed within the last three years • Original date approved and any renewal dates, if applicable	☐	
Letter of attestation, filled out and signed by your pharmacy manager/clinical coordinator/supervisor.	☐	
Evidence of 45 outpatient encounters or inpatient chart reviews with ≥ 2 interventions each within the previous 12 months from NCPS application submission date. Interventions and encounters must demonstrate comprehensive care.	☐	
Documentation of being Credentialed and Privileged through your local facility's medical staff. If no, please complete attached Credentialing and Privileging Waiver.	☐	
Clinical outcomes data reflecting most recently completed fiscal year (October 1 through September 30) for the most frequent disease states managed in your clinical practice; 2 or more required	☐	