OKLAHOMA STATE BOARD OF PHARMACY

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www.pharmacy.ok.gov / e-mail: pharmacy@pharmacy.ok.gov

Pharmacy Technician Application For Immunization Registration

(PORTABLE AND DOES NOT EXPIRE)

FOR OSBP USE ONLY	
RECEIPT:	
DATE:	

$25.00 - ONLINE ONLY

https://pay.apps.ok.gov/OSBP/Payments/

Technician Permit No. _____

Name _____

Address _____

City, State, ZIP _____

Primary Place of Employment _____ Pharmacy License # _____

Employer's Address _____

City, State, ZIP _____

I certify that I have read the "Technician Rules for Administering Immunizations [535:15-13-6.1]" and have completed the following approved training program(s) for administration of immunizations: *Please include Certificate of Completion and CPR Card*

Name of Program	Name of Provider / Sponsor	Completion Date

I swear and affirm under penalty of perjury pursuant to Title 21 O.S. 491 and/or discipline by the Board of Pharmacy under the pharmacy laws and rules of the State of Oklahoma that all information I have supplied herein is true and complete.

Technician Signature _____ **Date** _____

Pharmacist Review, Training & Competency Verification

I have reviewed the application as completed by the applicant and I verify that this applicant has been trained and is competent to administer immunizations to patients.

Pharmacist Signature _____ **Date** _____