

Application for Authorization To Administer Influenza Immunizations

South Dakota Board of Pharmacy
3701 West 49th Street, Suite 204
Sioux Falls, SD 57106
605-362-2737
www.pharmacy.sd.gov

Name _____

Address _____

City, State, ZIP _____

South Dakota pharmacist license number _____

NEW APPLICATION

_____ I have enclosed a copy of the Certificate of Completion of Approved Training Program for Administration of Influenza Immunizations which includes:

- basic immunology and the human immune response;
- mechanics of immunity, adverse effects, dose, and administration of an immunization
- administration of intramuscular injections; and
- record keeping and reporting requirements as set forth by § 20:51:28:05

_____ I have enclosed a copy of certificate of completion of current cardio-pulmonary resuscitation training and the date acquired.

RENEWAL APPLICATION

_____ I have enclosed a copy of the Certificate of Completion of a minimum of two hours of continuing education related to immunizations.

_____ I have enclosed a copy of certificate of completion of current cardio-pulmonary resuscitation training and the date acquired.

I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Date: _____ Signature: _____