



## SOUTH DAKOTA BOARD OF PHARMACY

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# Application for Authorization To Administer Influenza Immunizations

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Phone \_\_\_\_\_

(Please include area code.)

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 resuscitations 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 resuscitations 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 \_\_\_\_\_