

**APPLICATION FOR APPOINTMENT
BOARD OF PHARMACY
(HOSPITAL PHARMACIST MEMBER)**

PLEASE PRINT OR TYPE

Name:

First Middle Last Credentials (ie, PhD, etc., if applicable)

Mailing Address:

Street/Box/RR

City State Zip

Business Telephone _____ Cell/Pager _____ Residence Telephone _____

Email Address _____ FAX Number _____

Are you available to meet, usually in Lincoln, on a monthly basis, if necessary or required for Board Meetings? Yes No

Please indicate how you became aware of this vacancy on this Board. Professional Association DHHS Web Page
Newspaper Other (please explain) _____

ELIGIBILITY REQUIREMENTS

Do you hold a current Nebraska license to practice as a pharmacist? Yes No (Statutes require the pharmacist members of the board shall have held and maintained an active pharmacist license for a period of five years just preceding appointment and shall maintain such license while serving as a board member.)

Have you been actively engaged in practice as a pharmacist for the five (5) years just preceding this application? Yes No (Statutes require the pharmacist members of the board shall have been actively engaged in practice as a pharmacist for a period of five years just preceding appointment and shall maintain such practice while serving as a board member. Active practice means devoting a substantial portion of time to rendering professional services.)

Do you practice pharmacy within the confines of a hospital? Yes No (Statutes require membership of the board to consist of four actively practicing pharmacists, at least one of whom practices within the confines of a hospital)

Provide the number of years you have been engaged in the practice of pharmacy _____

Have you been a resident of the State of Nebraska for at least one (1) year? Yes No (Statutes require every member of the board shall have been a resident of Nebraska for one year and shall remain a resident of Nebraska while serving as a board member.)

EDUCATION

School Location Degree/Specialty Date Completed

PLEASE COMPLETE REVERSE SIDE

**DETAILED DESCRIPTION OF WORK EXPERIENCE AS A HOSPITAL PHARMACIST WITHIN THE
LAST FIVE YEARS IN NEBRASKA**

Position Title	Name & Location	From	To	Average # Hours/ Week
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ADDITIONAL INFORMATION

Describe your interest in this profession and why you wish to serve on this Board.

Are you aware of any reason why your appointment might be considered a conflict of interest as defined in Title 172 NAC 3, Regulations Establishing Definitions of Conflicts of Interest for Members of the Boards of Examiners in the Health Professions? Yes No If yes, explain.

Have you ever had your statutory ability to practice or clinical privileges suspended or revoked? Yes No

Are you currently under investigation? Yes No

Are you a veteran of the U.S. Armed Forces, or National Guard? Yes No
If yes, is your military experience related to your current practice? Yes No

I swear and affirm that all information I have provided on this application is true and complete to the best of my knowledge.

Signature

Date

**Return completed Application to: Monica Gissler, State Board of Health,
DHHS, Division of Public Health, LU/RPQI, P.O. Box 95026, Lincoln, NE 68509-5026
402/471-6515; FAX 402/471-0383; Monica.gissler@nebraska.gov**