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 in a hospital setting 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 five-year period 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

Degree/Specialty	School Name & Location	From	To	Completion Date

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 Number of Hours Per 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