Pharmacy Quality Assurance Commission
PO Box 47877
Olympia, WA 98504-7863
360-236-4700

Date Stamp Here

Pharmacy Technician Education and Training Program Approval Form

The complete program of study including resource materials, content of instruction, and detailed program administration must accompany this application as well as a description of the criteria for admission or selection into the training program, and details on how the program will measure the student's proficiency.

Application Type

☐ Original ☐ Renewal

Check One

☐ Association	☐ Limited Partnership	☐ Public Hospital District
☐ Corporation	☐ Municipality (City)	☐ Sole Proprietor
☐ Federal Government Agency	☐ Municipality (County)	☐ State Government Agency
☐ Limited Liability Company	☐ Non-Profit Corporation	☐ Tribal Government Agency
☐ Limited Liability Partnership	☐ Partnership	☐ Trust

1. Demographic Information

UBI #	Federal Tax ID (FEIN) #

Legal Owner/Operator Name

Mailing Address

City	State	Zip Code	County

Phone (enter 10 digit #)	Cell (enter 10 digit #)	Fax (enter 10 digit #)

Legal Name of Institution or Employer-based Program

Physical Address

City	State	Zip Code	County

Facility Phone (enter 10 digit #)	Cell (enter 10 digit #)	Fax (enter 10 digit #)

Mailing Address

City	State	Zip Code	County

Email address	Web Address

2. Type of Program

Please check which type of pharmacy technician education and training program or school.

☐ Formal/Academic Training ☐ On-the-job Training at a licensed pharmacy ☐ Vocational Training

☐ Military Training ☐ Other, explain ____________________

3. Contact Information

Name of Contact Person	Title

Physical Address

City	State	Zip Code	County

Email Address	Phone (enter 10 digit #)

4. Program Director Information

Attached additional pages if the training program uses multiple directors.

Name of Program Director

Title

Pharmacist Credential Number	Preceptor Certification Number

Physical Address

City	State	Zip Code	County

Email Address	Phone (enter 10 digit #)

5. Additional Pharmacies and Program Directors

List all pharmacies associated with this training program.

Pharmacy Name and Address	Pharmacy License #	Program Director	Pharmacist's License #

6. Signature

I certify that I have received, read, understood, and agree to comply with state laws and rules regulating education and training programs. I also certify that the information herein submitted is true to the best of my knowledge and belief.

Program Director/authorized representative

Date

Print Name

Print Title

Additional Forms and Resources

Pharmacy Webpage

Guidelines to Implementation