



**VERIFICATION OF OPIOID EDUCATION COMPLETED AS PART OF AN ACPE-ACCREDITED SCHOOL OF PHARMACY'S PHARM.D. OR B.S. IN PHARMACY PROGRAM**

**APPLICANT INFORMATION**

<b>NAME:</b> Last	First	Middle
<b>OTHER NAME(S):</b>		
<b>DATE OF BIRTH :</b>	<b>LAST 4 DIGITS OF SSN:</b>	
<b>ADDRESS:</b>		
<b>CITY / STATE / ZIP:</b>		

**ACCREDITATION COUNCIL FOR PHARMACY EDUCATION-ACCREDITED SCHOOL OF PHARMACY INFORMATION**

<b>NAME OF PHARMACY SCHOOL:</b>	
<b>ADDRESS:</b>	
<b>CITY, STATE, ZIP:</b>	
<b>PHONE NUMBER:</b>	
<b>PRINT NAME OF PHARMACY SCHOOL DEAN/REGISTRAR:</b>	
<b>EMAIL ADDRESS OF PHARMACY SCHOOL:</b>	

The following information must be completed by the pharmacy school dean/registrar and must verify that the applicant successfully completed at least 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids as part of their ACPE-accredited Pharm.D. or B.S. in Pharmacy program. Note: ACPE is the Accreditation Council for Pharmacy Education.

I hereby certify that the above listed applicant successfully completed 2 hours of education in pain management or the identification of addiction and 2 hours of education in the practices of prescribing or dispensing of opioids as part of their ACPE-accredited Pharm.D. or B.S. in Pharmacy program on \_\_\_\_ / \_\_\_\_ / \_\_\_\_.  
Month Day Year

I verify that the above statements are true and correct as validated by my review of the applicant's records. I verify that the information communicated on this form is true and correct to the best of my knowledge, information and belief. I understand that any false statement made is subject to the penalties of 18 Pa. C.S. §4904, relating to unsworn falsification to authorities.

Original Signature of Pharmacy School Dean/Registrar:	Date:	Month	Day	Year
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**THE SCHOOL MUST DIRECTLY SUBMIT THE ORIGINAL FORM TO:**