



American Society of Health-System Pharmacists (ASHP)
 4500 East-West Highway, Suite 900
 Bethesda, MD 20814
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SPECIALTY PHARMACY PRACTICE ACCREDITATION

APPLICATION

Complete the following information for each pharmacy seeking accreditation.

PHARMACY BUSINESS		
Corporate Name		Doing Business As Name, If Different
Pharmacy URL(s)		
Address (1)		Address (2)
City	State	Zip Code
Telephone Number	Fax Number	Pharmacy or Pharmacist-in-Charge (PIC) E-mail Address
Pharmacy License Number and Expiration Date		Drug Enforcement Administration (DEA) Registration Number and Expiration
State Controlled Substance License, If Applicable, and Expiration Date		Federal Employee Identification Number
National Provider Identification (NPI) Number		Medicare Billing Number, If Applicable
National Council for Prescription Drug Programs (NCPDP) Number		Medicaid Provider Number(s), If Applicable

PHARMACIST IN CHARGE

PHARMACIST IN CHARGE			
PIC/Full Name (First, Middle, Last)		PIC/CPE Monitor Number (If Applicable)	
PIC/Degrees Earned (Highest-Earned Listed First)			
PIC/Credentials and Certificates Held			
CREDENTIAL NAME		GRANTING ORGANIZATION	
PIC/States of Licensure			
STATE	LICENSE #	ISSUE DATE	EXPIRATION DATE

SUPPLEMENTAL DOCUMENTS

Required Documentation Demonstrating Compliance with Criteria

ASHP reviews the submitted documents and specifically looks for certain policies and procedures believed to be essential to meeting the intent of the ASHP criteria. When submitting information for which ASHP has provided a template, it may be utilized or you may provide Microsoft Excel files that are similarly formatted. Do not send blank templates. You will be notified via e-mail if ASHP finds any of the submitted materials unacceptable or in need of clarification.

1. Provide an organizational chart depicting pharmacy personnel. The PIC and his/her immediate supervisor, if applicable, must be charted.
2. List any additional states and territories in which the pharmacy is licensed or registered. The list must include the state of licensure, the license type, the license number, the license issue date, and the license expiration date. If your pharmacy ships or intends to ship to residents of states and territories that do not require nonresident pharmacy licensure, list the names of those states and territories. *A template is attached.*
3. List the additional pharmacists on staff. Include licensure information for each state in which the pharmacist is licensed or registered, including the license number and expiration date. Include the highest degree earned and any additional credentials or certificates, including the organization granting the credential or certificate. *A template is attached.*
4. List the technicians on staff. Include state license/registration information, including the type of registration, the number and expiration date, and certification information, if applicable, including the certification organization, the number, and expiration date. Also include any additional credentials or certificates, including the organization granting the credential or certificate. *A template is attached.*
5. Provide a chart outlining the legal business entities from the ultimate parent company to, and including, the applicant. The organizational chart should include the legal business name, doing business as name, corporate address, and the type of ownership for each legal business entity on the organizational chart. Additionally, list the names of the owners of the legal entities, including:
 - If a sole proprietorship, the full name of the sole proprietor and the home address of the individual.
 - If a partnership, the full name of each individual and the home address of the individuals.
 - If a corporation, the name and title of each corporate officer and director and the name of the state of incorporation.
 - If a limited liability company, the name of each member, the name of each manager, and the name of the state in which the limited liability company was organized.All owners with greater than 5% interest are to be included.
6. Disclose any (if applicable) relationships between owners of the pharmacy. For example, disclose if the owners are married, parent/child, or are siblings.
7. Disclose whether the owners have any ownership/controlling interest in any other pharmacies, including the names and addresses of the other businesses and the percentages owned.

8. Provide a copy of the most recent board of pharmacy inspection report and a narrative of any corrective action taken as a result (if applicable).

9. Disclose whether the pharmacy participates in any central fill or central processing activities. Describe.

10. Disclose whether the pharmacy has any contractual relationships with other pharmacies (not under common ownership) or health care entities to provide services. Describe.

11. Disclose whether any of the pharmacy functions are performed offsite (documentation of the activity will not be present at the facility) such as Human Resources, a legal department that verifies licensure, or a corporate office that performs recall notification and processing. List.



Additional Pharmacy Licenses

Pharmacy Name:	
Pharmacy Address:	

	State Where Licensed	Licensing or Registration Body	Type of License or Registration	License or Registration Number	Issue Date	Expiration Date
1						
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Pharmacist Data

Pharmacy Name:	
Pharmacy Address:	

	Pharmacist Name	Highest Degree Earned	Staff or Relief	State of License or Registration	Registration Type	Registration Number	Registration Expiration date	Additional Credential or Certificate	Organization Granting Credential or Certificate
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Technician Data

Pharmacy Name:	
Pharmacy Address:	

	Technician Name	State of License or Registration	Registration Type	Registration Number	Registration Expiration date	Certification Organization	Certification Number	Certification Expiration Date	Additional Credential or Certificate	Organization Granting Credential or Certificate
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