Washington State Department of Health
Pharmacy Technician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Director's Certification
Pharmacy Technician Education and Training

This form is used to report education and training received through a Pharmacy Quality Assurance Commission approved Technician Training Program.

The Director's Certification form **must be** completed and signed by the training program director as identified and on file with the Department of Health, Pharmacy Quality Assurance Commission. Any sections left blank will result in an incomplete or deficient application.

Note: The designated program director must sign the certification.

I declare under penalty of perjury under the laws of the state of Washington the following is true and correct:

I attest that the applicant has successfully completed the Pharmacy Quality Assurance Commission approved program of study and training to become a pharmacy technician.

I attest that the program consisted of the required instructional and supervised practical hours required; not to exceed 12 months. The program included at a minimum the following topics:

1. Legal aspects of pharmacy practice such as law and rules governing practice.
2. Hygiene/aseptic techniques and safety considerations.
3. Terminology, abbreviations and symbols.
4. Components of a prescription and patient medication record.
5. Drug dosage forms, routes of administration and drug product packaging, weighing and measuring, packaging and labeling, drug nomenclature, drug standards and information sources.
6. Pharmaceutical calculations.
7. Identification of drugs by trade and generic names, and therapeutic classifications.
8. Ordering, restocking, and maintaining drug inventory.
9. Computer applications in the pharmacy.
10. Communication techniques and confidentiality of information.

Applicant's Name:	
Dates of instructional and supervised practical training as a pharmacy technician: Start Date: Completion Date:	
Is this pharmacy technician training program credentialed or approved by the Pharmacy Quality Assurance Commission? ☐ No ☐ Yes Credential/Approval number _____ (enter n/a if this does not apply)	
Training Program or Pharmacy Name:	License Number (if applicable):
Address:	Telephone Number:
Director's Name (printed):	Director's License Number(s):
Director's Email:	Director's Phone Number:
Director's Signature:	Date (mm/dd/yyyy):