

## **CDM MAINTENANCE APPLICATION**

The CDM Maintenance process assures the profession, as well as the public, that NISPC credentialed pharmacists are evaluated periodically to verify that their knowledge and skills are kept current. NISPC requires all credentialed pharmacists to provide proof of education within their specialty area each year. Carefully read the *CDM Maintenance Requirements and Guidelines* before completing this application. Follow the steps below to complete the CDM maintenance process.

### **STEPS TO MAINTAIN YOUR CDM**

1. Review the *CDM Maintenance Requirements and Guidelines* as well as the *Application*.
2. Complete and **sign** the continuing education record.
3. Complete and **sign** the application.
4. *Attest that you have* a current, valid pharmacist license.
5. Enclose the application fee. Make checks payable to "NISPC" or submit credit card information online.
6. Submit the information on-line or mail the completed application, continuing education record and payment in the enclosed envelope to:

NISPC  
1600 Feehanville Drive  
Mount Prospect, IL 60056

Visit NISPC's web site at [www.nispcnet.org](http://www.nispcnet.org)

## CONTINUING EDUCATION RECORD

List completed continuing education programs. You may photocopy this blank form if more space is needed. **DO NOT ATTACH COPIES OF YOUR CONTINUING EDUCATION CERTIFICATES.**

**Please print or type. You must fill out a separate form for each disease state.**

PROGRAM TITLE	PROVIDER	ACPE APPROVED CE OR CME #	DATE HOURS EARNED	# OF HOURS
TOTAL # HOURS				

I affirm, under penalty of perjury, that the information I have submitted on this record is true and correct to the best of my knowledge and belief. I declare that I am a NISPC credentialed pharmacist.

\_\_\_\_\_  
Signature *(Required)* Date

\_\_\_\_\_  
Name *(Please print)* Disease State

# CDM MAINTENANCE APPLICATION

Identify the disease state(s) in which you are seeking to maintain:

- Anticoagulation Certificate #: \_\_\_\_\_ Year Received \_\_\_\_\_
- Asthma Certificate #: \_\_\_\_\_ Year Received \_\_\_\_\_
- Diabetes Certificate #: \_\_\_\_\_ Year Received \_\_\_\_\_
- Dyslipidemia Certificate #: \_\_\_\_\_ Year Received \_\_\_\_\_

## Personal Information

Name: \_\_\_\_\_  
Last Middle Initial First

Office Address: \_\_\_\_\_  
Street City State Zip

Residence: \_\_\_\_\_  
Street City State Zip

Send mail to: \_\_\_\_\_ Office address \_\_\_\_\_ Residence address

Home Phone: \_\_\_\_\_ Office Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Title: \_\_\_\_\_

## Payment

Check all that apply:

- \$50 Anticoagulation
- \$50 Asthma
- \$50 Diabetes
- \$50 Dyslipidemia

Grand Total: \$ \_\_\_\_\_

Method of Payment:

- Check payable to NISPC enclosed Check# \_\_\_\_\_
- VISA MasterCard American Express payment made online

## Licensure

- I affirm, under penalty of perjury, that my pharmacist license is current and valid in the state where a substantial portion of my practice takes place.

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Signature (*Required*)

Date

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Name (*Please print*)

Disease State

## Application Acknowledgment

- I have read and comprehend all the information contained in the *Requirements and Guidelines*.
- I have enclosed the application fee.
- I have attested to my current, valid, pharmacist license.
- I understand that NISPC will continue to include my name and address under the list of credentialed pharmacists on the NISPC websites.
- Check here if you would like for your name NOT to be included in the list of NISPC credentialed pharmacists on the above-mentioned websites.
- I understand that NISPC reserves the right to audit my CE certificates at anytime.
- I affirm, under penalty of perjury, that the information I have submitted on this application is true and correct to the best of my knowledge and belief.

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Signature

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Name (Please print)

Date

NISPC  
1600 Feehanville Drive  
Mount Prospect, IL 60056