

**PHARMACY TECHNICIAN POLICY**  
**(THIS POLICY SHOULD BE TYPED OR COMPUTER GENERATED)**

(This form can be accessed, typed, and printed from our website at [www.phcybrd.state.mn.us/forms/techapp1.pdf](http://www.phcybrd.state.mn.us/forms/techapp1.pdf))

**A copy of this policy must be given to each technician and kept on file in the pharmacy.**

NAME OF PHARMACY: \_\_\_\_\_ DATE: \_\_\_\_\_

PHARMACY ADDRESS: \_\_\_\_\_ LICENSE #: \_\_\_\_\_

\_\_\_\_\_ PHCY PHONE #: \_\_\_\_\_

PHARMACIST-IN-CHARGE: \_\_\_\_\_ LICENSE #: \_\_\_\_\_

1. Please describe, in detail, the anticipated duties of your technician(s). You may attach a copy of the technician's position description. **Do not list clerical or pharmacist duties:**

2. This employee will be used in (check all that apply):  
 Dispensing  Unit Dose  I.V. Program  Pre-Packaging  Bulk Compounding

3. Will a pharmacist be physically present at all times the technician is performing technician duties in the pharmacy?

\_\_\_\_\_

4. What will the technician-to-pharmacist ratio be?  
\_\_\_\_\_ 1:1  
\_\_\_\_\_ 2:1  
\_\_\_\_\_ 3:1 (IV admixture preparation, unit dose filling, prepackaging, or bulk compounding only)  
\_\_\_\_\_ 2+1:1 (see Mn Statute 151.102)

5. What words will be printed on the technician's name tag to identify the technician as such to the public?

\_\_\_\_\_

6. List the name(s), address(es), and registration number(s) of the individual(s) who will be filling the technician position:

NAME	ADDRESS	REGISTRATION #
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Describe the individual steps the pharmacist will take to check (certify the accuracy) of each prescription worked on by the technician? Also, please elaborate on how the pharmacist visually checks the labeled stock container when performing this certification. **PLEASE REFER TO MINN. RULE 6800.3100, SUBPART 3 BEFORE ANSWERING THIS QUESTION!**

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8. Where will the pharmacist be placing his or her initials immediately after checking (certifying) each prescription before it is dispensed?

COMMUNITY/OUTPATIENT:

New Rx's: \_\_\_\_\_

Refill Rx's: \_\_\_\_\_

IN-PATIENT:

stat orders: \_\_\_\_\_

unit dose: \_\_\_\_\_

IV's: \_\_\_\_\_

9. Describe the training this technician will receive: \_\_\_\_\_

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10. Where will patient counseling take place in the pharmacy? \_\_\_\_\_

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11. Describe how counseling will occur? **PLEASE REFER TO MN. RULE 6800.0910 BEFORE ANSWERING THIS QUESTION.**

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12. I certify that I have read and am familiar with the provisions of Minn. Rules:  
\_\_\_\_\_ 6800.3100, \_\_\_\_\_ 6800.3850, \_\_\_\_\_ 6800.0910, and \_\_\_\_\_ 6800.3110.

\_\_\_\_\_  
Pharmacist-in-charge  
(Signature)

\* See Minnesota Rule 6800.3850 Subpart 4.

\* The Board expects that your technician(s) be familiar with the contents of this application.