Candidate Full Name: ___________________________
PTCB Account ID: ________________

Supervisor Attestation Form for the PTCB Medication History Certificate Program

PTCB requires documentation to demonstrate that candidates have met the eligibility requirements to earn the Medication History certificate. This form must be completed by a supervisor who directly observed the activities of the Medication History candidate. The candidate is required to submit the form by logging into their PTCB Account.

Candidate Information
Full name: ____
PTCB Account ID: ____

Candidate Eligibility Requirements
Select your completed pathway. ☐ Pathway 1: Completion of a PTCB-Recognized Medication History Education/Training Program and at least 6 months of experience conducting medication histories and/or similar experiences of patient-focused communication (such as intake of new patients/prescriptions and answering patient questions). ☐ Pathway 2: At least 12 months of full-time employment with experience conducting medication histories and/or similar experiences of patient-focused communication (such as intake of new patients/prescriptions and answering patient questions).

The following two sections must be completed by your supervisor (or former supervisor).

Supervisor Information
Full name: ____
Employer address (street, city, state, ZIP code): ____
Supervisor job title: ____
Supervisor phone number: _______________________________
Supervisor email address: ____

Candidate Full Name: ________________________
PTCB Account ID: ______________

License/registration number (if applicable):
- ❏ Pharmacist _______________________
- ❏ Pharmacy Technician ________________________
- ❏ Other credential(s) ________________________

Supervisor Attestation

I, ____, do hereby certify that the information on this form is true and correct to the best of my knowledge. I understand that material misrepresentations on this form may affect the eligibility of the candidate for the PTCB Medication History Assessment-Based Certificate Program, and that PTCB may refer misrepresentations on this form to state regulatory bodies for review.
Select one of the following options:

- ☐ I certify that the applicant has at least 6 months of experience conducting medication histories and/or similar experiences of patient-focused communication (such as intake of new patients/prescriptions and answering patient questions).

- ☐ I certify that the applicant has at least 12 months of full-time employment with experience conducting medication histories and/or similar experiences of patient-focused communication (such as intake of new patients/prescriptions and answering patient questions).

Signature of Supervisor ________________________________

Date: _____/_____/__________