THE NATIONAL BOARD *of*
MEDICATION THERAPY MANAGEMENT
Advancing the Highest Standards for Better Health Outcomes

EXAM APPLICATION FOR GROUP DISCOUNT PROGRAM

The following information applies to individuals submitting their BCMTMS™ exam application *in the same package* along with those of at least *nine (9) other exam applicants*.

Thank you for your interest in NBMTM's BCMTMS™ exam and the group discount program!

If you are applying as part of a group of 10 or more to sit for the **BCMTMS™** exam via *computer-based testing*, please use the application on the following pages. Discounted group rates are as follows:

Exam	Regular Fee (USD)	Group Fee (USD)
BCMTMS™ Examination	$410	$380

APPLICANTS

- General policies for the MTM certification exam program including day of exam rules, recognition and use of credentials, obtaining a duplicate score report and name or address changes are available in the *Candidate Handbook* at www.nbmtm.org/board-certification/apply/candidate-handbook.
- Eligibility and exam preparation information for the BCMTMS™ exam is available in the handbook at www.nbmtm.org/board-certification/apply/candidate-handbook.
- Review the handbook ***prior*** to applying for the exam and retain a copy for reference.
- Complete the 2-page application.
- Provide your completed exam application and fee to your group coordinator/contact person.

AFTER APPLICATION IS SUBMITTED

- Once your application has been processed, you will receive an email and your Notification to Schedule (NTS) by email from Scantron confirming your board eligibility.
- Your NTS email will include exam scheduling information and the eligibility window during which you must schedule and sit for your computer-based exam.
- Upon receipt of your NTS, promptly go to Scantron website to schedule your testing appointment.
- For admission to Scantron testing centers, you must present 1 piece of identification with a current photograph. *No forms of temporary identification will be accepted.*
- Testing is offered year-round.

EXAM RESULTS

- Results of your exam will be provided within 4 weeks.
- Those who pass the exam will also receive a wall certificate by mail within 6 to 8 weeks of testing.

GROUP COORDINATORS/CONTACT PERSONS

Please refer to page 7 for details about requesting the group discount and mailing of applications.

Thank you for your commitment to MTM certification.
For questions, please contact us at contact@nbmtm.org or call 202-489-0506.

CONTENTS

GROUP DISCOUNT EXAM APPLICATION

For use only by individuals submitting their exam application in the same envelope with at least 9 other applicants.

1. REGISTRATION INFORMATION

PLEASE PRINT CLEARLY. PROCESSING WILL BE DELAYED IF INCOMPLETE OR NOT LEGIBLE. LEGAL NAME AS IT APPEARS ON YOUR GOVERNMENT-ISSUED ID CARD IS REQUIRED FOR EXAM.

RPH LICENSE: _____
Number State Exp. Date

LEGAL NAME: _____
Prefix Last First MI Suffix Maiden (Option)

HOME ADDRESS: _____
City State ZIP Country

EMAIL: _____ **HOME PHONE:** _____

EMPLOYER NAME: _____ **BUSINESS PHONE:** _____

EMPLOYER ADDRESS: _____

2. EXPERIENCE WAIVER FOR WHICH YOU ARE APPLYING

Waiver Type	*Check **one** box only*	Provide the following Supporting Documentation
MTM Training Course	☐	Copy of Certificate
Master's Degree in MTM	☐	Copy of Certificate
Residency	☐	Copy of Certificate

☐ Check this box if you've attached a request and supporting documentation for special testing accommodations.

3. PAYMENT INFORMATION – *application must be accompanied by payment*

Check or money order attached – payable to **National Board of Medication Therapy Management**. U.S. funds only.

Please complete page 2 of application.

GROUP DISCOUNT EXAM APPLICATION

PRINTED NAME

4. DEMOGRAPHIC INFORMATION

Check **one** box in each category. Information used for statistical purposes and may be used in eligibility determination.

Pharmacy Degree

☐Doctor of Pharmacy Degree (PharmD)
☐Master of Pharmacy (M.Sc.)
☐Bachelor of Pharmacy (BPharm)
☐Doctor of Philosophy in Pharmacy (PhD)

Post Graduate Degree

☐MD
☐DO
☐OD
☐PhD
☐MBA
☐Other – *specify below*

_____

Primary Type of Facility in Which Employed

☐College/University
☐Retail Pharmacy
☐Community Hospital
☐Corporate/Industry
☐HMO/Managed Care
☐Federal Hospital
☐Long-Term Care Pharmacy
☐Military/Government Hospital
☐Self-Employed
☐Other – *specify below*

_____

Pharmacy School Name

_____

Country

_____

Year Awarded

_____

Date of Birth: *(mm/dd/yyyy)*

_____

Gender: ☐ Female ☐ Male

5. SUBMIT APPLICATION

Attach Supporting Documents to this application and submit with payment to your group coordinator/contact person.

NOTE: Allow **2 to 4 weeks** from date received by NBMTM for processing of exam applications submitted via the Group Discount Program.

I hereby apply for the BCMTMS™ exam. Submission of this application indicates I have read and understand the exam policies and eligibility requirements as documented in the *Candidate Handbook*.

AUDIT: I understand that my certification application is subject to audit, and failure to respond to or pass an audit will result in revocation of certification.

ETHICS: I understand the importance of ethical standards and agree to abide by the Code of Ethical and Professional Conduct.

NON-DISCLOSURE OF EXAM CONTENT: Submission of this application indicates my agreement to keep the contents of the exam confidential and not disclose or discuss specific exam content with anyone except NBMTM. Per NBMTM policy, sharing of exam content is cause for revocation of certification.

To the best of my knowledge, the information contained in this application is accurate and submitted in good faith. My signature below indicates I have read this honor statement and meet the eligibility requirements as outlined.

Applicant's Signature: **Date:**

Questions? Please visit www.nbmtm.org, email contact@nbmtm.org or call us at 202-489-0506.

Did you include your signed application and fee payment?

EMPLOYMENT VERIFICATION

The National Board of Medication Therapy Management (NBMTM) believes that clear evidence of having met its direct practice experience requirement is as critical to demonstrating competence as is successful completion of its examination. Only those who are able to conclusively demonstrate having achieved 2 years of MTM experience in the upper extremity are permitted to sit for the BCMTMS™ examination.

It is the responsibility of the candidate to substantiate having met NBMTM's direct practice experience component to the satisfaction of NBMTM before NBMTM may determine whether a candidate is eligible to sit for the certification examination.

The Employment Verification Form must be returned, signed by your employer or supervisor. A pharmacist who is self-employed, or who was self-employed during any time, is permitted to sign the form; however, any self-verification must include as an attachment proof of ownership/partnership in a private practice such as a business license (e.g. pharmacy license or NCPDP registration) or partnership agreement (e.g. contract with Mirixa or OutcomesMTM).

A pharmacist who is unable to obtain verification may use this form to self-certify, however, inaccurate or false representation may lead to penalties including, but not limited to, revocation or denial of certification, recertification, or eligibility for certification.

Questions? Please visit www.nbmtm.org, email contact@nbmtm.org or call us at 202-489-0506.

EMPLOYMENT VERIFICATION FORM

BCMTMS™ Examination

Note to Employer: You are being asked to complete this form for an employee or former employee who is a candidate for the BCMTMS™ Examination. Each candidate must document **2 years of direct practice experience** in medication therapy management. Please complete this form and return to the candidate so it can be included in the application packet. If you have any questions, please contact the National Board of Medication Therapy Management, at (202) 489-0506. Thank you for your assistance.

Please Print Clearly or Type:

Candidate's Name _____ Candidate's Job Title _____

Facility Where Experience was Acquired _____

Address _____ City/State/Zip Code _____

This employment represents: _____ years of MTM experience acquired

between_____ and _____ .

By signing below, I certify that the information listed here are true and correct to the best of my knowledge and that I have personally verified them for accuracy. I am aware that my inaccurate or false representation may lead to penalties, including, but not limited to, NBMTM's refusal to accept further verification from me.

For Self-Verification: In addition, I understand that if I am the candidate listed above and signing this form because I am in private practice, or I am unable to obtain verification of my employment, my inaccurate or false representation may lead to penalties including, but not limited to, revocation or denial of my certification, recertification, or eligibility for certification.

Signature _____ Date _____

Name _____ Title _____

Work Address _____ City/State/Province _____

Telephone/Ext. _____ Relationship to Candidate _____

Please Note:

- Candidates should submit only as many forms as needed to verify 2 years of MTM experience.
- This form may be duplicated if needed for more than one employer.
- Candidates in private practice may sign their own form. Proof of ownership/partnership in a private practice is required.
- This form is to be used only by BCMTMS™ Initial Certification; it should not be used for Recertification.

Questions? Please visit www.nbmtm.org, email contact@nbmtm.org or call us at 202-489-0506.

INFORMATION FOR GROUP COORDINATORS/CONTACT PERSONS

NBMTM offers discounted exam application fees to employers or Pharmacy Organizations submitting **ten (10) or more applications together** in one packet.

Proper payment for each exam must accompany the applications.

All applicants must meet eligibility requirements for the BCMTMS™ exam and thoroughly review the *Candidate Handbook* ***prior*** to applying.

The group contact person is responsible for collecting and submitting all applications for the group and will need to:

- Set an internal due date to receive all applications.
- Collect all applications and payments, and review for completeness.
- Use the cover sheet on the next page (or create your own form using a similar format) to list the names and exam types of all applicants in your group. The form must also note an email address and phone number of the group contact person.
- Submit cover sheet, applications, and fee payment(s) in the same package to:

National Board of Medication Therapy Management
ATTN: Application Processing Center
PO Box 45121
Tampa, FL 33677

The group contact person will be notified via email when the group of applications is received. An email and Authorization to Test letter with exam scheduling information will be sent to each applicant.

For questions, please email contact@nbmtm.org or call 202-489-0506

COVER SHEET FOR GROUP APPLICATION SUBMISSIONS

To be completed by group contact person and returned to NBMTM with 10 or more exam applications and fee payment(s).

GROUP CONTACT NAME: _____ **DATE:** _____
Last First

GROUP CONTACT EMAIL ADDRESS: _____

GROUP CONTACT PHONE NUMBER: _____

PHARMACY ORGANIZATION NAME: _____

PHARMACY ORGANIZATION CITY, STATE, ZIP: _____

*Applicant **Last** Name*	*Applicant **First** Name*	*Exam Fees Included*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
Total # of applicants: (*10 or more needed*)		**Total for Exam Fees** $

If more than 20 applicants, use additional sheet.

Total Fee Payment(s) Included: $

Submit cover sheet, applications and fees to:

National Board of Medication Therapy Management
ATTN: Application Processing Center
PO Box 45121
Tampa, FL 33677