*** Submit this page with application ***

FOR OFFICE USE ONLY
Receipt #
ID #
Issue Date
License #

State of Rhode Island
Board of Pharmacy

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

Licensure as a Pharmacy Technician

Check Box: ☐ Tech I

☐ Tech II

MILITARY STATUS ELIGIBILITY *(Documentation Required) see next page for instructions*

Please check ONE of the following criteria for expedited application:

- ☐ I am in active military duty or a reservist
- ☐ I am a military veteran with honorable discharge
- ☐ I am the spouse of someone in active military duty or the spouse of a reservist

Applicant - Print Name

LAST NAME	*FIRST NAME*	*MI*

Phone: (401) 222-2828 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-1272**

Revised 11/16/2018 jcp

LICENSURE REQUIREMENTS

- ☐ Completed Application with Cover Page - Applications are valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you must submit a new application. The license expires annually on June 30th. Licenses issued prior to April 21st will be required to renew by July of the same year. You may not practice until your license is issued.
- ☐ Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the amount of **$25.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- ☐ Copy of Driver's license for proof of age - must be 18 years or older (with the exception of those high school students working in pharmacies as part of school or community sponsered career exploration programs);
- ☐ High-school graduate or the equivalent, or currently enrolled in a high school or vocational training program that awards such degree or certificate. Complete the qualifying education section within this application.
- ☐ If applying for TECH 1 - completed Pharmacist In Charge Affidavit section within this application.
- ☐ If applying for TECH 2 - Copy of certificate of successful completion of PTCB or EXCPT Certification Examination.
- ☐ If you have ever been licensed in another state, **you** must request that license verification(s) be sent directly from each state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used for that purpose)
- ☐ If applying for expedited military status you must include one of the following: Leave Earning Statement (LES), Letter from Command, Copy of Orders or DD-214 showing honorable discharge.

Licensure Information

Please visit the RIDOH website at **http://www.health.ri.gov/licenses** to Verify your license, download Rules and Regualtions/Laws for your profession, download change of address forms, other licensing forms or obtain our contact information. HEALTH will not, for any reason, accelerate the processing of one applicant at the ex pense of others.

High-School Career Exploration Programs

High school students working in pharmacies as part of school or community sponsored career exploration programs shall be exempt from the requirements of this section and shall not be required to be licensed as pharmacy technicians.

IMPORTANT: DO NOT SUBMIT AN APPLICATION FOR A PHARMACY TECHNICIAN LICENSE IF YOU ARE ALREADY LICENSED AS A PHARMACY INTERN.

State of Rhode Island
Board of Pharmacy

Application for License as a Pharmacy Technician I or Pharmacy Technician II

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/Permit/Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."

3. Gender

☐ Male ☐ Female

4. Date of Birth

Month Day Year

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address

(Tech I's MUST list Pharmacy Name and Address)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Qualifying Education

Please list the name and information about the high school that you last attended.

Type of School (High School, University, College, Trade/Technical School etc.)

Name of School

State

Date Graduated: Month Day Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

9. Technician II Certification

☐ Check here if not applicable

Complete the following information if you have received certification from one of the following: a) ASHP; b) US Armed Services or US Public Health Service; c) Regionally accredited College or University Program or secondary educational program; d) PTCB or EXCPT Certification examination. If not, check the box on the left for "not applicable".

Date Issued: Month Day Year

CPhT No.:

10. State Licenses

List all states in which you are now, or ever have been licensed to practice as a Pharmacy Technician.

☐ Check here if not applicable

State: ☐ Active ☐ Inactive

State: ☐ Active ☐ Inactive

State: ☐ Active ☐ Inactive

State: ☐ Active ☐ Inactive

State: ☐ Active ☐ Inactive

State: ☐ Active ☐ Inactive

DOCUMENTATION: YOU must send Interstate Verification Forms to each state listed above.

11. Pharmacist-in-Charge Affidavit

To be signed by the pharmacist-in-charge (PIC) or supervising Pharmacist of the pharmacy. For Pharmacy Technician I ONLY

NOTE: Your application will be returned to you if this section is not completed.

I hereby certify that the applicant: _____

Applicant Name **REQUIRED**

Is a Pharmacy Technician I and will receive training as required.

Date Hired (**in a Technician I capacity**) Month Day Year

Pharmacy Name: _____

PIC Name (Printed) _____

Signature: _____

Date Signed _____

12. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

13. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1. Are there any charges or investigations pending, in any state, against you? ☐ Yes ☐ No

2. Have you ever had a membership in a professional society revoked, suspended, or limited in any manner, or have you voluntarily withdrawn while under investigation? ☐ Yes ☐ No

3. Have you ever had any disciplinary action(s) taken, or is any pending against your license to practice as a pharmacy technician, or any other licenses, registrations or certifications that you hold; or are any complaints pending in any state? ☐ Yes ☐ No

Note: If you answered "yes" to any of these questions you must explain on a separate sheet of paper.

No convictions of any felony for violations involving controlled substances (subject to waiver by the Board upon presentation of satisfactory evidence that such conviction does not impair the ability of the person to conduct with safety to the public the duties of a Pharmacy Technician 1.

14. Affidavit of Applicant

Complete this section and sign.

Make sure that you have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Rhode Island Board of Pharmacy any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as Pharmacy Technician in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Pharmacy of any change in the answers to these questions after this application and this affidavit is signed.

_____ Signature of Applicant

_____ Date of Signature (MM/DD/YY)

Substitute forms are not acceptable - This form may be duplicated as needed .

Rhode Island Board of Pharmacy
Room 104, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-1272

INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

THIS SECTION TO BE COMPLETED BY APPLICANT AND SENT TO OTHER STATE(S)

I am applying for a license to practice as Pharmacy Technician I or Pharmacy Technician II in the State of Rhode Island. The Rhode Island Board of Pharmacy requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Pharmacy at the above address.

Print/Type Full Name

Signature _____ Date _____

Previous Names Used

Social Security Number Date of Birth

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE PHARMACY BOARD

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Reason for Inactive Status:

Questions:

1. Has this licensed technician ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensed technician incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name

Title

Full Name of Licensing Board

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.