*** Submit this page with application ***

	Submit this page with applic	alion				
FOR OFFICE USE ONLY		***FOR OFFICE USE ONLY***				
 □ App. & Fee □ Copy of Driver's License/ID □ Copy of Out-of-State Pharmacist License □ Interstate Verification(s) □ Proof of Military Status (If Applicable) 	CHOOL WISLAND					
		Receipt #				
		ID#				
	POPE	Issue Date				
		License #				
S	tate of Rhode Isla	nd				
Center for Professional Licensing Board of Pharmacy Room 104 3 Capitol Hill Providence, RI 02908-5097						
Instructions and Application For License To Practice Pharmacy By Reciprocity						
	Pharmacist					
	Yes No Tem	porary 90-Day License				
MILITARY STATUS	ELIGIBILITY	(Documentation Required) see next page for instructions				
Please check ONE of the	e following criteria for expedited					
☐ I am in active military	duty or a reservist					
	in with honorable discharge omeone in active military duty o	r the spouse of a reservist				
Applicant - Print Name						

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

FIRST NAME

LAST NAME

MI

<u>Licensure Checklist</u>						
	leted Application with Cover Page - Applications are valid for 1 year from the day they are received at H. If you are not licensed within the year you must submit a new application.					
☐☐ of \$28	Check or money order (preferred), made payable (in U.S. funds only) to the RI General Treasurer in the am of \$280.00 and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLITION FEE IS NONREFUNDABLE.					
Сору	of driver's license or state issued id					
Сору	Copy of Current out-of-state pharmacist license.					
in whi	If you have ever been licensed in another state, license verification(s) must be sent directly from the state(s) in which you hold or have held a license. (Interstate Verification Form included in this application can be used that purpose)					
	lying for expedited military status, please complete the Military Expedition Form at the end of this ation packet.					
<u>Licensure F</u>	<u>Process</u>					
M tal	oply with NABP (National Association of Boards of Pharmacy) at https://nabp.pharmacy to take the RI PJE Multistate Pharmacy Jurisprudence Examination). Please check with NABP for the fee associated with king this examination. You must pass this exam before you can request Reciprocity/License Transfer rough the NABP.					
	oply with NABP (National Association of Boards of Pharmacy) at https://nabp.pharmacy for your formation to be sent to Rhode Island for your license application by reciprocity.					
<u>Licensure I</u>	<u>nformation</u>					
	- a 90 day Temporary Pharmacist license will be granted while you wait for the passage of the RI MPJE and cense Transfer from the NABP.					
must submit a	re valid for 1 year from the day they are received at RIDOH. If you are not licensed within the year you new application. The license expires annually on June 30th. Licenses issued prior to April 21st will be new by June of the same year. You may not practice until your license is issued.					
	he RIDOH website at http://www.health.ri.gov/licenses to Verify your license, download Rules ons/Laws for your profession, download change of address forms, other licensing forms or obtain formation.					
HEALTH will	not, for any reason, accelerate the processing of one applicant at the expense of others.					
Mail this appli	cation to: Rhode Island Department of Health Center for Professional Licensing Board of Pharmacy 3 Capitol Hill, Room 104 Providence, RI 02908					
License Certi	<u>ficates</u>					
	providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for check the box below and attach a separate check in the amount of \$30.00 made payable to RI General Treasure					
	like to receive a license certificate. I have enclosed a separate check in the amount of \$30.00					



State of Rhode Island Board of Pharmacy

Application for License to Practice Pharmacy by Reciprocity

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens. 1. Name(s) Title (i.e., Mr., Mrs., Ms., etc.) This is the name that will be printed on your License/Permit/Certificate and reported First Name to those who inquire about your License/ Middle Name Permit/Certificate. Do not use nicknames, etc. 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). "Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as 2. Social Security amended, I attest that I have filed all applicable tax returns and paid all Number U.S. Social Security Number 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 Please select from the dropdown. 4. Date of Birth Month Dav 5. Home 1st Line Address (Apartment/Suite/Room Number, etc.) **Address** It is your responsibility to notify the board of all Second Line Address (Number and Street) address changes. 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** Name of Business/Work Location (ONLY if it is **RELATED** to 1st Line Address (Department/Suite/Room Number, etc.) your license.) Second Line Address (Number and Street) It is your responsibility to notify the board of all address changes. City State Zip Code This address will appear on the De-Postal Code, If NOT U.S. Country, If NOT U.S partment of Health web site. **Business Phone** Extension **Business Fax**

Applicant: Print your complete last name >

7. Preferred Mailing Address	Please use my Home Address as my preferred mailing address Please use my Business Address as my preferred mailing address					
Please check ONE	, , , , , , , , , , , , , , , , , , ,					
8. Qualifying Education	Type of School (College or University)					
Please list the name and information about the college or university that you last attended.	Name of School State Date Graduated: Month Day Year					
	Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)					
9. Other State Licenses	State:					
List all states in which you are	Active Inactive Active Inactive					
now, or ever have been licensed as a	Active Inactive Active Inactive					
pharmacist or have applied for licensure	Active Inactive Active Inactive					
	DOCUMENTATION: You must send an Interstate Verification Form to at least one state listed for an active license above (form on page 8).					
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? Abbreviation of State and Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance): Month Year Year					
11. Disciplinary Questions Check either Yes or No for each	Have you ever had any disciplinary action(s) taken, or is any pending, against your License to Practice, or are any complaints pending in the State of Rhode Island or any other state? Yes No					
question. NOTE: If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and	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. Are there any charges or investigations pending, in any state, against you?					
disposition of the matter.	4. Have you ever failed to pass an examination for licensure as a pharmacist?					
	Note: If you answered "yes" to any of these questions you must explain below or, if needed, on a separate sheet of paper.					

12. e-Profile ID	a Profile ID						
Please provide the e-Profile ID that is pro- vided by the NABP.	e-Profile ID Please visit the NABP webiste at https://nabp.pharmacy in order to get information on how to obtain this ID.						
13. Affidavit of Applicant Complete this section and sign . Make sure that you	I,, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.						
have completed all components accu- rately and completely.	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 my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.						
	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) 222-2828

INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

I am applying for a license to practice as a registered pharmacist in t following form be completed by the jurisdiction in which I obtained a lice or otherwise, directly to the Rhode Island Board of Pharmacy at the a	ense. This constitutes your authority to rel				
Print/Type Full Name	Signature		Date		
Previous Names Used	Social Security Number	Da	Date of Birth		
License Number Date Issued					
THIS SECTION TO BE COMPI	LETED BY THE PHARMA	CY BOARD			
License Status:	Original Date Issued:	Expiration Date:			
Reason for Inactive Status:					
Questions:					
Has this licensed technician ever been investigated by your Board	☐ Yes	□ No			
2. Has this licensed technician incurred any disciplinary proceedings	Yes	□ No			
3. Has the applicant's license ever been denied, surrendered, reprim 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 explan complaint, etc.).	nation below, and attach a copy of all supp	oorting documentatio	n (e.g., Board order,		
Certification:					
Signature	Date	_			
Type or Print Name		Please Affix Board Seal Here			
Title					
Full Name of Licensing Board					
Please return directly to the Board at the al	bove address. Thank you for your pro	ompt cooperation.			



Rhode Island Department of Health Military Expedition Form

Please attach this form to the *front* of your completed application and mail to the address shown on the application cover.

Pursuant to Rhode Island General Laws § <u>5-88-1</u> et seq., upon application, this state may recognize occupational licenses, certificates or permits obtained from other states for military members and their spouses who relocate to this state pursuant to military orders. The Rhode Island Department of Health (RIDOH) will expedite your or your spouse's health professional license application provided the following conditions are met.

I. PROFESSION/LICENSE TYPE

Please indicate the profession and/or license type you are applying for so that your application can be routed to the correct office:

Profession/License Type:

II. MILITARY STATUS

Please check ONE of the following criteria for expedition:

I am in active military duty or a reservist.

I am the spouse of someone in active military duty or the spouse of a reservist.

I am a military veteran with honorable discharge. You do not need to complete the rest of this application – please skip to the signature line.

III. PROOF OF MILITARY STATUS

Please attach a copy of proof of your military status such as one of the following: Leave Earning Statement (LES), Letter from Command, or Copy of Orders

IV. MILITARY CHANGE OF STATION ORDER

Permanent Change of Station Order

V. PROOF OF GOOD STANDING

Proof of good standing from the board in the other state in which the person has a license.

VI. Criminal Background Check (a "BCI") (unless required in the initial license application) BCI completed from the RI Attorney General's Office.

VII. ATTESTATIONS:

Check all that apply:

No board in any other state has revoked the license for which I am applying as a result of negligence or intentional misconduct.

I have never surrendered an occupational license, certificate, or permit because of negligence or intentional misconduct.

I do not have a complaint, allegation, or investigation currently pending before a board in another state which relates to unprofessional conduct or an alleged crime.

I attest that the above responses and information are true and accurate to the best of my knowledge and that none of the information set forth above is false, erroneous, or defective in any important, as set forth in R.I. Gen. Laws § 11-18-1. I understand that this application is being made to the Rhode Island Department of Health, which shall rely upon my attestation and the information provided in this document.

Signature of Applicant

Date