

*** Submit this page with application ***

FOR OFFICE USE ONLY

- App. & Fee
- Copy of Driver's License/State ID
- Out of State License Verification (If Applicable)
- Proof of Military Status (If Applicable)

FOR OFFICE USE ONLY

Receipt #

ID #

Issue Date

License # PHL



**State of Rhode Island
Board of Pharmacy**

Room 104
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

**Limited License as a
Pharmacy Intern**

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

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 **\$70.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- Proof of Age - 18 years or older - Submit a copy of driver's license or state issued id
- College Certification - section within this application must be completed by an authorized individual of the college of pharmacy. Applicant must be enrolled in at least the first year of a program from an accredited college of pharmacy.
- 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.

Foreign Pharmacy Graduates Licensing Requirements

- Requirements listed above,
- Completion of a course of study from a college of pharmacy located outside the United States, which is listed in the World Directory of Schools of Pharmacy, published by the World Health Organization.
- Obtained **full certification** from the Foreign Pharmacy Graduate Equivalency Commission (FPGEC), administered through the National Association of Boards of Pharmacy (NABP). Only the official **FPGEC Certificate** will be accepted by the Board, and it is a prerequisite to applying for licensure. Information on the Foreign Pharmacy Graduate Certification Program can be obtained by accessing the Foreign Pharmacy section on its website: <https://nabp.pharmacy>

Licensure Information

Please visit the RIDOH website at <http://www.health.ri.gov/licenses> to Verify your license, download Rules and Regulations/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 expense of others.



State of Rhode Island Board of Pharmacy

Application for Limited License as a Pharmacy Intern

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.

Provide the approximate starting date for accruing internship hours in the boxes located at the top, right-hand corner of the application.

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 Division of Taxation to verify that no taxes are owed to the State.”

3. Gender

Please select from the dropdown.

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

Country, if NOT U.S.

 -

Home Phone

State

 -

Zip Code

Postal Code, if NOT U.S.

 -

Home Fax

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

6. Business Address

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

Name of Business/Work Location

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

Second Line Address (Number and Street)

City

Country, if NOT U.S.

 -

Business Phone

State

 -

Zip Code

Postal Code, if NOT U.S.

 -

Business Fax

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

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

Second Line Address (Number and Street)

City _____ State _____ ZipCode _____ Phone _____

8. Qualifying Education

Please list the name and information about the University/College that you currently attend.

Type of School (University, College)

Name of School

Date Enrolled: Expected Date of Graduation:

Month Day Year Month Day Year

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

Major

Specialty Type Credit Hours

As evidence that the student is enrolled in at least the first year of a professional degree program in an accredited college of pharmacy, the Dean, or an appointed designee, must complete Section 13, entitled **“College Certification”**.

9. Licensures

List all states or country that you are now licensed as an intern, technician, or pharmacist, or have applied for licensure.

State/Country/License Type: _____ State/Country/License Type: _____

_____ Active Inactive Pending _____ Active Inactive Pending

_____ Active Inactive Pending _____ Active Inactive Pending

_____ Active Inactive Pending _____ Active Inactive Pending

Check here if not applicable

10. 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 of, or plead Nolo Contendere, to any federal, state or local statute, regulation, or ordinance or entered into a plea bargain related to a felony (including convictions for driving under the influence?) Yes No

Abbreviation of State and Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):

_____ Month Year

_____ Month Year

_____ Month Year

For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

11. 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. 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 state? 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. Are there any charges or investigations pending, in any state, against you? Yes No
- 4. Have you ever failed to pass an examination for licensure as a pharmacist? Yes No

Note: If you answered "yes" to any of these questions you must attach a typed explanation, on a separate sheet of paper.

12. 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) _____

13. College Certification

This certification is to be signed by the Dean of the College of Pharmacy or an appointed designee as evidence that the student is enrolled in at least the first year of a professional degree program in accredited college of pharmacy.

Application will be returned if not completed.

I hereby certify that the applicant for a limited license, to serve a pharmacy internship in this state under a preceptor, is enrolled in at least the first year of a professional program of an accredited college of pharmacy.

Authorized Individual:

Name (Printed) _____

Signature _____

Date Signed _____



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 a pharmacy intern 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: <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed	Original Date Issued:	Expiration Date:
Reason for Inactive Status:		
Questions:		
1. Has this licensed technician ever been investigated by your Board?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has this licensed technician incurred any disciplinary proceedings in your state, or is any action pending?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Do you know of any information that may discredit this person?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.). <hr/> <hr/> <hr/>		

Certification:

Signature	Date
Type or Print Name	
Title	
Full Name of Licensing Board	



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