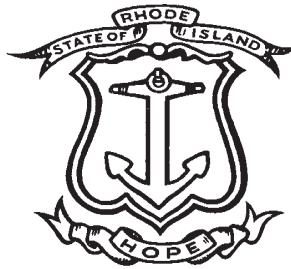


*** Submit this page with application ***



FOR OFFICE USE ONLY

Receipt #

ID #

Issue Date

License # RPH

-T

State of Rhode Island Board of Pharmacy

Room 103
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

Temporary 90-Day License to Practice Pharmacy by License Transfer

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) 222-2837

TTY/TDD: (800) 745-5555

Fax: (401) 222-2158

GENERAL INFORMATION

Enclosures

The following materials and information are enclosed with this application packet:

Application Process Overview	2
Instructions for Completing Board Application	3
Application Materials:	
Board Application	5-7
Interstate Verification Form	8

Licensure Requirements

- Completion of a first professional degree program in pharmacy located within the United States, which is accredited by the American Council on Pharmaceutical Education, or full certification by the Foreign Pharmacy Graduate Equivalency Commission (FPGEC).
- Active licensure (in good standing) as a practicing pharmacist in another U.S. state.
- License Verification from the Board of Pharmacy in which you are practicing.

Military Expedited

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.

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professions Regulation, and the Rhode Island Board of Pharmacy (BOARD). The BOARD utilized the National Association of Boards of Pharmacy (NABP) for administration of the licensure examinations. All licensure applicants must complete and submit a HEALTH application, and all required documentation, prior to applying to the NABP for the licensure examinations.

Application Process

In addition to the BOARD's application, you must submit additional information directly to the BOARD. All items listed on the "checklist" (page) must be submitted for an application to be considered complete.

Eligibility for the MPJE examination will be declared only if the BOARD has received the NABP Official Application, and any other requested documentation.

HEALTH will not, for any reason, accelerate processing of one applicant at the expense of other applicants. Once completed, the application will be reviewed, and you will be contacted in writing.

NOTE: You may **not** practice in Rhode Island until a temporary license has been issued. The license will expire 90-days from the date of issuance, and is not renewable.

GENERAL INFORMATION (Continued)

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the BOARD application. If you have any questions about this application process, or would like to check on the status of your BOARD application, please contact the BOARD at (401)222-2837.

Licensure Examination

The BOARD requires the NABP Official Application for Licensure Transfer from the NABP as the application for licensure as a pharmacist in this state. This application is valid for six months from the day it is received at HEALTH. If you do not complete the application process and obtain a license by license transfer within those six months, a new BOARD application and fee must be submitted. You will receive this application from NABP after completing their Preliminary Application online.

The BOARD requires successful passage of the Multistate Pharmacy Jurisprudence Examination (MPJE) for Rhode Island. The MPJE is a state-specific law examination, and the BOARD will not accept the score attained for another state. Please complete the preliminary application for NABP and also register to take the RI MPJE at www.nabp.net

Applications are considered valid for six months from the day they are received at HEALTH. If you do not complete the application process and obtain license by transfer within those six months, a new application and fee must be submitted.

Examination(s) Failure

The BULLETIN outlines the procedure for applying for reexamination of the MPJE, including the NABP's waiting period between examinations.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the BOARD application. Only complete applications will be accepted. Failure to submit all required information may result in processing delays. All of the information provided is subject to change.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type the information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. It is suggested that a copy be made of the completed application before submitting it to the Board.
5. Incomplete applications will be returned unprocessed.
6. It is the applicant's responsibility to check on the status of the application.

Completing your Board Application

1. Complete the Board Application (pages 5-8). Respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages MUST clearly indicate the section for which such information is being reported.
2. Attach a birth certificate (original or a copy notarized as being a “true copy of the original”). For applicants born outside the United States, attach proof of lawful entry.
3. One (1) recent identification photograph of the applicant, head and shoulders, front view, approximately 2 x 2 inches in size. The photograph must be submitted with the application.
4. The application must be notarized.

APPLICATION CHECKLIST

- I have read and understand the “Instructions for Completing the Application.”
- I have completed the Rhode Island Board application as instructed.
- I have completed Section 12, “Affidavit of Applicant”, and had the form notarized by a notary public.
- I have attached a notarized copy of my birth certificate or proof of lawful entry as instructed.
- I have attached a photograph to Section 13, “Recent Photograph” (page 7) as instructed. I have verified that it meets the photograph requirements as stated in the application.
- I have attached a check or money order, made payable (in U.S. funds only) to the “Rhode Island General Treasurer” in the amount of \$280.00.
- I have requested verification of licensure in good standing from another state Board of Pharmacy.
- I have completed the NABP Preliminary application online.



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)

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 Division 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

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 (ONLY if it is RELATED to your license.)

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

Country, If NOT U.S.

 -

Business Phone

Extension

State

Zip Code

 -

Postal Code, If NOT U.S.

 -

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 college or university that you last attended.

Type of School (University or College)
Name of School
Date Graduated:
<div style="text-align: center;"> <input type="text"/> <input type="text"/> <small>State</small> </div> <div style="text-align: center;"> <input type="text"/> <input type="text"/> <input type="text"/> <small>Month Day Year</small> </div>
Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

9. Other State Licenses

List all states in which you are now, or ever have been licensed as a pharmacist or have applied for licensure



State:	State:
<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Active <input type="checkbox"/> Inactive
<input type="checkbox"/> Active <input type="checkbox"/> Inactive	<input type="checkbox"/> Active <input type="checkbox"/> Inactive

DOCUMENTATION: You must send an Interstate Verification Form to at least one state listed for an active license above (form on page 8).

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, 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 Conviction¹ (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

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 other 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 explain below or, if needed, on a separate sheet of paper.

12. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public 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 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)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp)

Signature of Notary

Notary Seal



Notary No./Commission No.

Commission Expiration Date (MM/DD/YY)

13. Recent Photograph

Securely tape or glue a passport type 2" x 3" photograph.



Provide the date that the photograph was taken.

Date of Photograph



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

Rhode Island Board of Pharmacy

Room 103, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-2158

INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

I am applying for a license to practice as a registered pharmacist 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:

- Has this licensed technician ever been investigated by your Board? Yes No
- Has this licensed technician incurred any disciplinary proceedings in your state, or is any action pending? Yes No
- Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? Yes No
- 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.