*** Submit this page with application ***

FOR OFFICE USE ONLY

- ☐ App. & Fee
- ☐ Photograph
- ☐ Proof of Pharmacy Degree
- ☐ Internship Hours
- ☐ NAPLEX
- ☐ MPJE
- ☐ FPGEC (Foreign Grads
- ☐ Proof of Military Status (If Applicable)
- ☐ Verification Out of State License(s)

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
License To Practice Pharmacy By Examination

Pharmacist

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 12/16/2020 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 **$280.00** and attached to the upper left-hand corner of the first (Top) page of the application. THIS APPLICATION FEE IS NONREFUNDABLE.
- ☐ Attach a 2 x 2 passport size photograph taken within the past year to the photograph section of this application.
- ☐ Official transcript from a college of pharmacy, located within the United States and is accredited by the American Council on Pharmaceutical Education. Transcript must include date of graduation, degree conferred and experiential hours accrued. Transcript must be sent directly from the college to the Board. See below if you are a graduate from a college of pharmacy outside the United States.
- ☐ Submit the **Preceptor Affidavit of Internship Hours** (form included in this application for that purpose. This affidavit verifies completion of 1,500 internship hours of practical experience under the supervision of a licensed pharmacist. Each preceptor under whom internship hours were accrued must complete an affidavit. The form may be duplicated as needed. If you filed internship hours with another state, request that board to forward a **Verification of Internship Hours** directly to the Rhode Island Board. You may obtain the mailing address and telephone numbers of all U.S. licensing authorities at the NABP website: https://nabp.pharmacy
- ☐ Passage of both the North American Pharmacist Licensure Examination (NAPLEX) and the Rhode Island Multistate Pharmacy Jurisprudence Examination (MPJE), examinations which are administered through the National Association of Boards of Pharmacy (NABP). Please visit https://nabp.pharmacy and download the BULLETIN located in the Examination section on the website. The BULLETIN will provide you with all procedures regarding the exami-nation processes. The NABP will electronically report the NAPLEX and MPJE scores to the Board.
- ☐ 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 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.

License Certificates

RIDOH will be providing wallet license cards ONLY on issuance of licenses. If you wish to receive a license certificate, suitable for framing, please check the box below and attach a separate check in the amount of $30.00 made payable to RI General Treasurer.

☐ I would 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 as a Pharmacist By Examination

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

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

Date Enrolled: Month Day Year   Date Graduated: Month Day Year

Degree Received (Bachelor of Arts, Doctor of Pharmacy, etc.)

Major

Specialty/Type   Credit Hours

DOCUMENTATION: Attach a letter from the dean of the college of pharmacy from which you graduated, which states the date of the graduation, the degree conferred, an the number of hours accrued under the experiential learning pharmacy practice course. This document must be the original (preferred), or a copy which has been **notarized as being a "true copy of the original".**

9. Pharmacist Licensure

List all states our country that you are now licensed as a pharmacist, or have applied for a license.

☐ Check here if not applicable

State/Country:				State/Country:			
______	☐ Active	☐ Inactive	☐ Pending	______	☐ Active	☐ Inactive	☐ Pending
______	☐ Active	☐ Inactive	☐ Pending	______	☐ Active	☐ Inactive	☐ Pending
______	☐ Active	☐ Inactive	☐ Pending	______	☐ Active	☐ Inactive	☐ Pending

DOCUMENTATION: You must send Interstate Verification Forms to each state listed above (page 9).

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

	Month	Year
______		
______		
______		

11. e-Profile ID

Please provide the e-Profile ID that is provided by the NABP.

e-Profile ID

Please visit the NABP website at **https://nabp.pharmacy** in order to get information on how to obtain this ID.

12. 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.

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.

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 submit a written explaination on a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign.

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

I, ___________________________________, affirm that the information provided on my application form and documentation provided to support my application is true, accurate, complete and unaltered. I acknowledge that pursuant to R.I.G.L. 11-18-1, knowingly making a false statement on my application form is punishable as a misdemeanor, and that such an act shall constitute cause for denial, suspension, or revocation of my license/permit to practice as a Pharmacist 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.

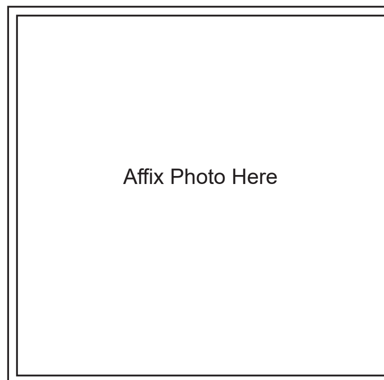
Signature of Applicant ____________________ Date of Signature (MM/DD/YY) ____________________

14. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos or computer-generated photos will not be accepted.



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) 222-2837

PRECEPTOR AFFIDAVIT OF INTERNSHIP HOURS

Applicant Should Complete this Section Only:

I hold a valid Limited License as a pharmacy intern, and the Rhode Island Board of Pharmacy requires that this form be completed by each licensed pharmacist who served as my preeceptor.

____
Print/Type Full Name

____
Previous Names Used

______________________________ ___________________
License Number Date Issued

*** FOR OFFICE USE***

Limited License No.___________________________

Date Issued: Training ________________________

Period Valid Hours ☐ Yes ☐ No

Accepted: _________________________________

THIS SECTION TO BE COMPLETED BY PRECEPTOR

I am a licensed pharmacist in the State of __________________________________. I am an owner, manager, department head, dean or employee at a licensed business or educational institution. I was the preceptor, or authorized official of an accredited college of pharmacy, of the above-listed intern, who satisfactorily completed practical experience under my supervision.

____
Print/Type Full Name

____
License Number

____
Previous Names Used

____
Pharmacy Name

____
License Number

____
Pharmacy Address

____
City, State, ZipCode

____
Signature of Preceptor Date

Intern's Training Period

Month	Day	Year	–	Month	Day	Year

Hours Accrued by Intern

☐

Rhode Island Board of Pharmacy
Room 104, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-2828

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 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: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**
Reason for Inactive Status:		

Questions:

1. Has this licensed pharmacist ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensed pharmacist 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 return directly to the Board at the above address. Thank you for your prompt cooperation.