PHARMACY INTERN REGISTRATION APPLICATION INSTRUCTIONS - RENEWAL

This application must be completed by Maryland registered Pharmacy Interns who are required to renew their registration in accordance with Md. Code Ann., Health Occ. §12-6D-02-15 and COMAR 10.34.38.07

- Complete the attached Maryland Board of Pharmacy's **Application for Pharmacy Intern Registration-Renewal**. This application is applicable to individuals renewing their pharmacy intern registration and who meets one of the following conditions:
    - Is currently enrolled in professional pharmacy education in a doctor of pharmacy program (program must be accredited by the Accreditation Council for Pharmacy Education or have pre candidate or candidate status by the Accreditation Council for Pharmacy Education); or
    - Has graduated from a doctor of pharmacy program accredited by the Accreditation Council for Pharmacy Education.

- Applications must be submitted with one of the two affidavits (completed and signed) attached to this application packet.

- Completed applications must be postmarked **at least two weeks prior to expiration of your current registration** to ensure that you can continue practicing while the Board completes processing of the application. The Board may return incomplete applications, which may cause your current registration to expire before you are renewed.

- If an application is received **less than two weeks prior to expiration** of the current registration, or if additional information is needed due to an incomplete submission, the Board cannot guarantee that your new registration will be issued prior to the expiration of your current registration.

- If a renewal application has not been processed prior to the end of your birth month because of an incomplete or untimely submission, **you may not practice pharmacy in Maryland until the registration is renewed**.

    - **Practicing without an active registration is a violation of the law and may result in disciplinary action by the Board of Pharmacy**.

- Submit the completed application with all required attachments and a check or money order made payable to the Maryland Board of Pharmacy in the amount of $ 45.00 to:
  Maryland Board of Pharmacy, P.O. Box 1991, Baltimore, Maryland 21203-1991
    - **Incomplete checks or money orders will be returned**

- Applications sent overnight or through priority mail must be addressed to the appropriate lockbox and sent to:
  Santander, Attn: State of Maryland Board of Pharmacy, Lock Box 1991
  100 Grove Rd., West Deptford, NJ 08086

    - **No applications with money orders or checks can be mailed to the office**

- A registrant's business address is **public information**. If the business address is not available,

the registrant's home address may be released upon request under the Public Information Act, Maryland Code Annotated, General Provisions § 4-333(b)(2).

- If you are interested in volunteering for the Emergency Preparedness Task Force, please Visit: http://dhmh.maryland.gov/pharmacy/Pages/emergency-preparedness-information.aspx for more information and/or email MDresponds.dhmh@maryland.gov to register.

NOTE: The application fee is a non-refundable, administrative fee.

Maryland Board of Pharmacy
4201 Patterson Avenue
Baltimore MD 21215-2299
Phone: 410-764-4755
Fax: 410-358-6207
www.health.maryland.gov/pharmacy

APPLICATION FOR PHARMACY INTERN REGISTRATION - RENEWAL

RENEWAL APPLICATION
☐**Total Due: $45.00**

Please print clearly in ink or type in upper case letters only.

Complete all application sections and sign**. Incomplete forms will delay the issuance of your license.**

VETERANS AND SPOUSAL PREFERENCE	
Are you an active service member of the spouse or an active service member?	☐ **YES** ☐ **NO**
Are you a veteran or the spouse of a veteran who was discharged from active duty under a circumstance other than dishonorable within one (1) year of filing this application?	☐ **YES** ☐ **NO**

1. IDENTIFICATION (ALL INFORMATION REQUIRED)					
First Name:					
Middle Name:					
Last Name:					
Social Security Number:					
Street Address:					
City:		**State:**		**Zip:**	
Home Phone:					
Work Phone:					
Cell Phone:					
Date of Birth:					
License #:		**Expiration Date:**			
Email Address:					

2. EMPLOYMENT INFORMATION					
Employer Name:					
Date of Hire:					
Street Address:					
City:		**State:**		**Zip:**	

3. CURRENT PHARMACY INTERN STATUS	
Check the category that best describes your current pharmacy intern status. Applicant must provide the additional documentation needed to validate this status.	
☐	Currently enrolled in a doctor of pharmacy program (pharmacy school) and has completed 1 year of professional pharmacy education in a doctor of pharmacy program (program must be accredited by the Accreditation Council for Pharmacy Education or have pre-candidate or candidate status by the Accreditation Council for Pharmacy Education): **You must provide proof of enrollment using Attachment 1: Pharmacy School Enrollment Affidavit.**
☐	Has graduated from a doctor of pharmacy program accredited by the Accreditation Council for Pharmacy Education: **You must provide proof of graduation using Attachment 2: Pharmacy School Graduation Affidavit.**

4. PHARMACY SCHOOL INFORMATION	
School Name:	
School Address (Including Country):	
School Phone Number:	
Graduation Date:	
Dates Attended:	
Degree Received:	☐BS Pharm. Pharm D.
Is the School ACPE Accredited?	☐YES ☐NO

5. REGISTRATION / LICENSURE HISTORY	
Have you applied for pharmacy registration or licensure in any other state?	☐YES ☐NO
If YES, disclose all places, dates and results below. Attach additional sheets if necessary.	

Name of State	Date of Application	Registration/License Issued?
		☐YES ☐NO
Date Licensed	**Registration/License Number**	**In Good Standing?**
		☐YES ☐NO

Name of State	Date of Application	Registration/License Issued?
		☐YES ☐NO
Date Licensed	**Registration/License Number**	**In Good Standing?**
		☐YES ☐NO

6. PERSONAL ATTESTATION QUESTIONS		
Please read this section carefully and answer the following questions related to your practice as a pharmacy intern. If you answer “yes” to any question, please provide a detailed explanation (attach additional pages if necessary) and supporting documentation. Failure to provide complete and correct information may result in delay, or denial, of your application for registration		
1. Has any state licensing or disciplinary board (including Maryland) or any similar agency in the Armed Forces, denied your application for a registration, reinstatement or renewal, or taken any formal disciplinary action against any registration or license held by you? Such actions include, but are not limited to, reprimand, suspension, or revocation.	☐YES	☐NO
2. Has any state licensing or disciplinary board (including Maryland) or similar agency in the Armed Forces filed any complaints or charges against you or investigated you for any reason?	☐YES	☐NO
3. Have you surrendered or failed to renew a healthcare registration or license in any state?	☐YES	☐NO
4. Have you ever withdrawn your application for a pharmacy intern registration or other health professional license?	☐YES	☐NO
5. Has your employment by any pharmacy, clinic, healthcare practice, or wholesale drug distributor been terminated for disciplinary reasons?	☐YES	☐NO
6. Have you committed a criminal act for which you pled guilty or nolo contendere (see definition below), or for which you were convicted or received probation before judgment?	☐YES	☐NO
7. Excluding minor traffic violations are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?	☐YES	☐NO
8. Have you committed an offense involving alcohol or controlled substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment?	☐YES	☐NO
9. Do you currently have a physical, mental, or emotional condition which adversely affects your practice as a pharmacy intern?	☐YES	☐NO
10. Do you currently use any illegal drugs or alcohol in a manner that adversely affects your practice as a pharmacy intern?	☐YES	☐NO

***** Nolo contendere- A plea in a criminal case which has a similar legal effect as pleading guilty. The defendant does not admit or deny the charges, but a fine or sentence may be imposed based on this plea.***

I affirm that the information I have given in answer to these questions is true and correct to the best of my knowledge and belief. I have read the Maryland Pharmacy Act, Section 12-101 *et. seq.*, Health Occupations Article, Annotated Code of Maryland, and Board regulations, COMAR 10.34.01 *et seq.*, and if licensed, I agree to practice pharmacy in accordance with laws of Maryland.

Signature:	
Date:	

7. LIST OF DESIGNEES		
If applicable, list the names of person and/or entity that you authorize the Board to release information about your application:		
Name of Organization	**Name of Person**	**Title**

8. APPLICATION CHECKLIST		
Application Fee	☐YES	☐NO
Proof of Current Pharmacy School Enrollment—Attachment 1 (if applicable)	☐YES	☐NO
Proof of Graduation from a Doctor of Pharmacy Program—Attachment 2 (if applicable	☐YES	☐NO
Birth Certificate or Other Proof of Birth Date	☐YES	☐NO

Would you like to be an emergency preparedness volunteer?	☐YES	☐NO

I, _____, do solemnly swear or affirm under the penalties of perjury that I have personally completed this application, that the foregoing information is true, correct and complete to the best of my knowledge and belief, and that I understand that any misrepresentation may constitute grounds for revoking this registration.

Applicant's Signature:	

Date:	

VOLUNTARY EQUAL OPPORTUNITY INFORMATION
To further its commitment to equal opportunity, the Board of Pharmacy requests applicants to VOLUNTARILY provide the following information. This information will be used for statistical purposes only by authorized personnel.

RACE:	**Are you of Hispanic or Latino origin?** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)	☐YES ☐NO

If you are not of Hispanic or Latino origin, select one or more of the following racial categories:	
1. American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)	☐
2. Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the India subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)	☐
3. Black or African American (A person having origins in any of the black racial groups of Africa.)	☐
4. Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)	☐
5. White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)	☐

APPLICATION FOR PHARMACY INTERN RENEWAL

ATTACHMENT 1

PHARMACY SCHOOL ENROLLMENT AFFIDAVIT

Name of Applicant:	
School of Pharmacy:	
Address of School:	
Year in School (Select one):	**3 4**
Expected Date of Graduation:	
Social Security #:	

STATEMENT OF PHARMACY SCHOOL ENROLLMENT
**** This section must be completed by the school/college of pharmacy ****

This is to certify that

_____

NAME OF STUDENT

is currently enrolled at_____ School/College of Pharmacy

Initial Enrollment Date:		
Projected Graduation Date:		
School Address:		
School Phone:		**SCHOOL SEAL**
Dean or Designee Name:		
Title:		

Dean or Designee Signature:	_____
Date:	
Phone Number:	

APPLICATION FOR PHARMACY INTERN

ATTACHMENT 2

PHARMACY SCHOOL GRADUATION AFFIDAVIT

The dean or registrar of your pharmacy school must complete this page unless you submitted an original Foreign Pharmacy Graduate Examination Committee (FPGEC) Certificate. The school seal **must** be placed on this page. **If this application is completed prior to graduation, the school must notify the Board after the applicant qualifies for graduation and has completed the experiential portion of his/her training.**

I certify that

_____

NAME OF STUDENT

attended the _____
School/College of Pharmacy

from _____ to _____

and earned _____ hours of actual pharmacy experience in a structured program conducted by or supervised by this School/College of Pharmacy, and on _____ graduated with the degree of _____.

Signed _____

Dean or Registrar

Print Name:	
Print Title:	
Today's Date:	

PLACE THE SCHOOL SEAL OR STAMP ON THIS PAGE