INITIAL PHARMACIST LICENSE APPLICATION INSTRUCTIONS: U.S. GRADUATES AND FOREIGN GRADUATES

This application must be completed by applicants who want to become licensed pharmacists in Maryland in accordance with Md. Code Ann., Health Occ. §12-301-305 and COMAR 10.34.02.

- Complete the attached Maryland Board of Pharmacy's (Board) **Initial Application for Pharmacist Licensure: U.S. and Foreign Graduates**.

- **To ensure accurate information from NABP and the Board, please indicate your E-Profile number on the licensure application.**

- Submit the completed application with all attachments and a check or money order made payable to the Maryland Board of Pharmacy in the amount of **$ 150.00** 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 sent to:

  Santander, Attn: State of Maryland Board of Pharmacy, Lock Box 1991
  100 Grove Rd, Suite F – Door 2, West Deptford, NJ 08066

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

- Following the Board's receipt of your application, you will receive a Candidate Number from the Board either by regular mail or e-mail. **Please allow two weeks for processing of your application.**

You are required to take the North American Pharmacist Licensure Examination (NAPLEX), and the Multistate Pharmacy Jurisprudence Examination (MPJE). These examinations are administered by the National Association of Boards of Pharmacy (NABP). You must apply to NABP to take these exams.

- After applying to NABP you will receive an "Authorization to Test" (ATT). The ATT will be issued only after you meet all application requirements and after payment to NABP. NABP will directly send you an e-mail that includes your ATT Number in order for you to schedule appointments to take authorized exams through Pearson VUE's website at www.pearsonvue.com/NABP.

- You must pass the NAPLEX and MPJE exams with a grade of 75 or better (scores are only good for one year from the date of examination.)

- If you are requesting a NAPLEX score transfer from NABP, please mark the appropriate box.

Once you have met all Board requirements and have passed all required exams, you will receive a letter from the Board that provides your new license number. You may use this letter as a temporary license until your printed license is received by mail. (You may also verify your licensure status on the Board's web site at www.mdh.maryland.gov/pharmacy.)

FOREIGN GRADUATES ONLY (in addition to the above):

- Must be Foreign Pharmacy Graduate Examination Committee (FPGEC) Certified with the National Association of Boards of Pharmacy ("NABP") online at www.nabp.net and provide the Board with a copy of the FPGEC Certificate.

- 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.mdh@maryland.gov to register.

NOTE: Your application will be good for one year from the date received by the Board. If you have not met all criteria within one year, you must resubmit an application and the applicable fees. Fees paid for applications that have expired will not be refunded or credited.

NOTE: Please allow seven to ten business days after receipt of your license number until you receive a printed license in the mail.

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

PDMP: Mandatory Use for Pharmacists

Pharmacists must query and assess the PDMP data when they suspect any CDS prescription is being filled for something other than treatment of an existing medical diagnosis, essentially a restatement of the corresponding responsibility under federal regulations.

Effective adoption of PDMP as a clinical decision support tool both under the use mandate, and as recommended by the Centers for Disease Control and Prevention (CDC), the President's Opioid Commission on Combating Drug. Addiction and the Opioid Crisis, and the Maryland Heroin and Opioid Emergency Task Force relies on
Integrating
PDMP data access into the realities of a put in place to assist providers are:

1. Use of Delegates, who can access the PDMP on behalf of a prescriber or pharmacist and provide that PDMP data report to the provider for a prescribing or dispensing decision
2. Integrating PDMP access into an EHR, which is available in many hospital system settings across the state

The full text of the use mandate can be found in Health General-Article §21-2A-04.2. For additional information.

Please refer to: https://bha.health.maryland.gov/pdmp/Pages/-Healthcare-Providers.aspx

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

INITIAL APPLICATION FOR PHARMACIST LICENSURE: U.S. AND FOREIGN GRADUATES

Place a recent photograph in this space

Attach a photograph showing your face, with a three quarter view. The photograph **must be recent and in good condition.**

Total Fee Paid: $150.00	☐

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.**

NABP E-PROFILE
#_____

I certify that this is a photograph of me taken within the previous 180 days of submitting this application.	
Applicant's Signature:	

1. Have you submitted an initial pharmacist application previously? ☐ YES ☐ NO
2. SCORE TRANSFER
Are you requesting a NAPLEX score transfer from NABP? ☐ YES ☐ NO

3. IDENTIFICATION ☐ Male ☐ Female					
First Name:					
Middle / Maiden Name:					
Last Name:					
Application Date:					
Street Address:					
City:		**State:**		**Zip:**	
Home Phone:					
Work Phone:					
Cell Phone:					
Social Security Number: **(require copy of proof)**					
Date of Birth:		**Place of Birth:**			
Email Address: **(required)**					

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4. 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**

5. FOREIGN PHARMACY GRADUATE EXAMINATION COMMITTEE (FPGEC) CERTIFICATE (FOREIGN APPLICANTS ONLY	
Provide your original Foreign Pharmacy Graduate Examination Committee (FPGEC) Certificate	
a. Date of Certificate:	
b. EE #:	

6. PHARMACY SCHOOL INFORMATION	
NOTE: All applicants who graduated from a school of pharmacy accredited by the Accreditation Council for Pharmacy Education (ACPE) must complete Attachment 1 – Pharmacy School Affidavit.	
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**

7. PHARMACY PRACTICE EXPERIENCE

An applicant shall complete <u>one</u> of the following as a prerequisite to Board licensure:

1. 1,000 hours in a school-supervised pharmacy practice experience program conducted by an ACPE-accredited school of pharmacy; **OR**

2. 1,560 hours of full-time training under the direct supervision of licensed pharmacists who are approved by the Board **(Foreign Graduates Only).**

If an approved school of pharmacy offers partial fulfillment of internship requirements as a part of its curriculum, time spent in a program by an applicant may be accepted by the Board on an equivalent basis to replace a portion of the required pharmacy practice experience training. This will be evaluated on an individual basis. In order to receive credit for experience outside of a structured pharmacy practice experience program conducted by an ACPE-accredited school of pharmacy, a notarized Pharmacy Experience Affidavit (Attachment 2), stipulating the time served in hours per week, from each employer must be submitted with the application or have been previously filed with the Board.
(cont'd)

NOTE: Internship hours must be certified by the Board of Pharmacy in the State in which the hours were earned.

Please complete the following:

a. Notarized Pharmacy Experience Affidavit(s) submitted?	☐ **YES** ☐ **NO**
Number of hours submitted with application:	
b. Notarized Pharmacy Experience Affidavit(s) on file with Board?	☐ **YES** ☐ **NO**

Number of hours on file with Board:	
c. School-supervised pharmacy practice experience program?	☐ YES ☐ NO
Number of hours earned:	
d. Certified Internship hours from out-of-state?	☐ YES ☐ NO
State:	
e. Number of hours earned:	
Total number of hours submitted:	

8. TRAINING ON ADMINISTRATION OF SELF-ADMINISTRED DRUGS	
a. I attest that I have the proper training on the Administration of Self-Administered Drugs per COMAR 10.34.39	☐ YES ☐ NO ☐ N/A
b. If "YES", do you have an active Certification in Basic Cardiopulmonary Resuscitation?	☐ YES ☐ NO
If "YES", provide expiration date:	

9. LICENSURE HISTORY	
A. Have you applied for licensure by reciprocity in any state?	☐ YES ☐ NO

If YES, disclose all places, dates and results below. Attach additional sheets if necessary.

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

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

B. Have you previously taken a board examination for licensure as a pharmacist in this or any other state?	☐ YES ☐ NO

If YES, disclose all places, dates and results below. Attach additional sheets if necessary.

Name of State	Date	Passed or Failed	License Issued?
			☐ YES ☐ NO
Date Licensed	**License Number**		**In Good Standing?**
			☐ YES ☐ NO

Name of State	Date	Passed or Failed	License Issued?
			☐ YES ☐ NO
Date Licensed	**License Number**		**In Good Standing?**
			☐ YES ☐ NO

10. PERSONAL ATTESTATION QUESTIONS	
Please read this section carefully and answer the following questions related to your practice as a pharmacist. 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 license, 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 pharmacist's license 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 ability to practice as a pharmacist?	☐ **YES** ☐ **NO**
10. Do you currently use any illegal drugs or alcohol in a manner that adversely affects your ability to practice as a pharmacist?	☐ **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:	

11. LIST OF DESIGNEE		
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**

APPLICATION CHECKLIST		
Application Fee	☐ **YES**	☐ **NO**
Recent Photograph	☐ **YES**	☐ **NO**
Social Security Card, Passport or Work VISA card (Copy)	☐ **YES**	☐ **NO**
FPGE Certificate (Foreign Applicants Only)	☐ **YES**	☐ **NO**
Certified Copy of Birth Certificate or Other Proof of Birth Date	☐ **YES**	☐ **NO**
Pharmacy School Affidavit (Attachment 1)	☐ **YES**	☐ **NO**
Notarized Pharmacy Experience Affidavit (Attachment 2)	☐ **YES**	☐ **NO**
Verification of Internship Hours by Appropriate State Board	☐ **YES**	☐ **NO**

The Maryland Board of Pharmacy complies with all applicable federal, state, and local statutes relating to the accommodation of disabilities. If you have a disability, you may request testing accommodations. To ensure that the security and integrity of the examinations are not compromised, the Board will evaluate accommodation requests in consultation with NABP. You are advised to request testing accommodations as early as possible.

Would you like to receive license renewal notification via email?	☐ **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 license

Applicant's Signature:	

Date:	

INITIAL APPLICATION FOR PHARMACIST LICENSURE
NEW OR FOREIGN GRADUATES

ATTACHMENT 1

PHARMACY SCHOOL 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:	
Date:	

PLACE THE SCHOOL SEAL OR STAMP ON THIS PAGE

INITIAL APPLICATION FOR PHARMACIST LICENSURE
NEW OR FOREIGN GRADUATES

ATTACHMENT 2:
PHARMACY EXPERIENCE AFFIDAVIT

(Please Fill In All Blank Spaces)

I, the undersigned, hereby certify that I am a licensed Pharmacist in the State of _____, License Number: _____,

and that _____ received practical pharmacy experience as follows:
(Applicant Name)

HOURS OF EXPERIENCE				
From	**To**	**# of Weeks**	**Hours Per Week**	**Hours Earned**
			TOTAL HOURS REPORTED ON FORM:	

I, _____,
(Supervising Pharmacist)
do solemnly swear or affirm, under the penalties of perjury, that I have personally completed this form to the best of my knowledge and belief, that I understand that perjury on this form will constitute grounds for revoking any license issued which uses this form as a supporting document.

State of _____; County or City of _____

SIGNATURE:	_____
PHARMACY:	
ADDRESS:	
DATE:	
IMPORTANT NOTICE: This affidavit must be notarized and submitted with application where appropriate.	