PHARMACIST LICENSE APPLICATION

INSTRUCTIONS – RECIPROCITY

This application is to be completed by pharmacists licensed in states other than Maryland who want to become licensed pharmacists in Maryland, in accordance with Md. Code Ann., Health Occ. §12-305 and COMAR §10.34.15.01.

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

- Complete the attached **Application for Pharmacist Licensure Reciprocity**, and the **NABP License Transfer Application** found on the National Association of Boards of Pharmacy ("NABP") website at www.nabp.net.

- Submit the completed Maryland Board of Pharmacy ("Board") application with all attachments and a check or money order made payable to the Maryland Board of Pharmacy in the amount of **$ 300.00** to:

  Maryland Board of Pharmacy, P.O. Box 1991, Baltimore, Maryland 21203-1991.
  - **Incomplete checks or money order 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
  101 Woodcrest Road, Suite 201, Cherry Hill, NJ 08003

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

- Submit a copy of the NABP License Transfer Application to the Board. (Do not submit any additional payment to the Board if you have already paid the $300 Board application fee.)

- After receipt of your application, the Board will email a candidate number to you. This number should be used whenever making inquiries to the Board about your application. **Please allow two weeks for processing of your application.**

- Once the Board application is received a complimentary Law Book will be provided by mail.

- Apply to NABP to take the Multistate Pharmacy Jurisprudence Examination (MPJE).

- After applying to NABP, you will receive an "Authorization to Test" (ATT) number from NABP. The ATT will be issued after you meet the application requirements and after payment to NABP. Upon receipt of the ATT number you may schedule an appointment to take the MPJE exam through Pearson VUE's website at www.pearsonvue.com/NABP.

- You must pass the MPJE with a score of 75 or higher. (ALL scores are only good for one year from the date of examination.)

- You must have completed at least 520 hours of pharmacy experience after graduation from a school of pharmacy approved by the Board or approved by ACPE.

Once you have passed the MPJE, you will receive an official letter from the Board of Pharmacy that includes your new license number. You may use this letter as a temporary license until your printed license is received. You may also verify your licensure status on the Board's web site at www.heath.maryland.gov/pharmacy

FOREIGN GRADUATES ONLY (in addition to the above):

- Must be Foreign Pharmacy Graduate Examination Committee (FPGEC) Certified with NABP 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.dhmh@maryland.gov to register.

NOTE: Your application will be valid 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://health.maryland.gov/pdmp/Pages/pdmp-use-mandate-information.aspx
Application link: https://health.maryland.gov/pdmp/Pages/PDMP-Forms.aspx
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.health.maryland.gov/pharmacy

APPLICATION FOR PHARMACIST LICENSURE RECIPROCITY

Total Fee Paid: $300.00	☐
NABP e-Profile # _____	

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

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

What date do you expect to begin working in Maryland? _____

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. Have you submitted a pharmacist application to the Board previously? ☐YES ☐NO

2. 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)					

3. PHARMACY SCHOOL INFORMATION					
Pharmacy School Name:					
Foreign Graduate?	☐ **YES** ☐ **NO**				
Address of Pharmacy School:					
City:		**State:**		**Zip:**	
Graduation Date:		**Degree Received:**	☐ Pharm D ☐ BS ☐ Other: _____		
Have you taken an Oral English Competency Exam?	☐ **YES** ☐ **NO**	**Type of Oral English Examination Taken:**			
Date Examination Taken:					

4. 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:	

5. LICENSURE HISTORY

Indicate licensure information about all current and previously held licenses to practice pharmacy. Attach additional sheets if needed. **Submit a written explanation for any license that is not in good standing**.

License Number & State	Original License Issue Date	License Expiration Date	Name, Address & Telephone Number of Last Employer

6. PERSONAL ATTESTATION QUESTIONS	
Please read this section carefully and answer "YES" or "NO" to 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 attach supporting documents to explain your answer. Failure to provide complete and correct information may result in delay, or denial, of your application.	
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 practice as a pharmacist?	**☐ YES ☐ NO**
10. Do you currently use any illegal drugs or alcohol in a manner that adversely affects your 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:	

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:	

7. LIST OF DESIGNEES

If applicable, list the names of person(s) and/or entity(ies) that you authorize the Board to release information about your application:

Name of Organization	Name of Person	Title

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 by authorized personnel for statistical purposes only.

RACE:	**Are you of Hispanic or Latino origin?**	☐ **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.)**	☐