PHARMACIST LICENSE APPLICATION INSTRUCTIONS – REINSTATEMENT

- This application must be completed by pharmacists who want to reinstate an expired Maryland pharmacist license in accordance with the Md. Code Ann., Health Occ. §12-310 and COMAR 10.34.13.

- **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 for the correct amount to:

Maryland Board of Pharmacy, P.O. Box 1991, Baltimore, Maryland 21203-1991

Effective May 27, 2024, 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
101 Woodcrest Road, Suite 201, Cherry Hill, NJ 08003

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

- Submit required CEs. A total of **30 Continuing Education Credit Hours (CEs)**, obtained within the last two years, are required to be submitted at the time you apply for reinstatement. Two (2) CEs must be live, one (1) CE must be on medication errors. A CE is considered "live" if it offers the ability for the participant to have real-time interaction with the presenter, including programs approved by the Accreditation Council for Pharmacy Education (ACPE) that are designated by the letter "L" in the course identification number.

- **Pursuant to MD. Code Ann., Health Occ. § 1-225, all health practitioners must attest to completing an implicit bias training program approved by the Cultural and Linguistic Health Care Professional Competency Program on their first license renewal after April 1, 2022.**

- To view and track continuing professional education credits from ACPE-accredited providers, all pharmacists should obtain a National Association of Boards of Pharmacy (NABP) e-Profile identification number. To view and track these credits, you must first set up an NABP e-Profile, obtain your NABP e-profile ID, and register for CPE Monitor. You can obtain more information on the NABP website at https://store.nabp.net/OA_HTML/xxnabpibeGblLogin.jsp. (Note: non-ACPE-accredited courses must be approved by the Board, and are not retrievable from CPE Monitor.)

- Pharmacists reinstating within their first renewal period **are not** required to submit CEs **if the original license was obtained within one (1) year of graduation**.

- CEs used to renew your Vaccine Certification can also be used to renew your license. **If you are renewing your Vaccine Certification, complete Attachment 2.**

In addition to the above:

A. If applying **within 2 years** of expiration of your license, enclose check or money order for: $527.00

B. If applying **more than 2 years** after expiration of your license, enclose check or money order for: $542.00

- Apply to take the MPJE with NABP online at (www.NABP.net.)
- After applying to NABP, you will receive an Authorization to Test (ATT). The ATT will be issued only after you meet all of the application requirements and after payment to NABP.NABP will send you an ATT number to use when scheduling the required examinations.
- Examination results will be forwarded electronically to the Board within 2-3 business days after the test is taken. Unofficial scores are posted on NABP's web site, www.NABP.net.

C. If applying **more than 5 years** after expiration of your license and you have not been actively engaged in the practice of pharmacy in another state, you must complete Attachment 1, Pharmacy Experience Affidavit, in addition to the above.

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

Your application will be valid for one year from the date received by the Board. If you have not met 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.

Maryland Board of Pharmacy

4201 Patterson Avenue
Baltimore MD 21215-2299
Phone: 410-764-4755
Fax: 410-358-6207

www.dhmh.maryland.gov/pharmacy

APPLICATION FOR PHARMACIST LICENSURE REINSTATEMENT

- Please print clearly or type in upper case letters only.
- Complete all application sections and sign. **Incomplete forms will delay the issuance of your license.**

If applying **within 2 years** of expiration of license, enclose check for:	If applying **more than 2 years** after expiration of license, enclose check for:
☐**Total Due: $527.00**	☐**Total Due: $542.00**
NABP E-PROFILE #	

1. 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:					
Date of Birth:					
Email Address:					
License Number					
Date of Initial Licensure:					
Initially Licensed in Maryland by:	☐ **EXAM** ☐ **RECIPROCITY**				
License Expiration Date:					

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**

2. EMPLOYER INFORMATION

List work experience for the past 2 years, including the name and address of each employer and the period of service. Attach additional sheets if needed. **If your license expired more than five years ago and you have not been actively engaged in the practice of pharmacy in another state, you must complete Attachment 1 – Pharmacy Experience Affidavit.**

EMPLOYER NAME	DATES OF EMPLOYMENT	ADDRESS & TELEPHONE #

3. 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:	

4. LICENSURE HISTORY

Indicate licensure information about all current and previously held licenses to practice pharmacy. Attach additional sheets if needed. **Submit a written explanation of 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

5. 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 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 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**
11.	**Have you worked as a pharmacist in a Maryland pharmacy or a non-resident Pharmacy serving Maryland residents since the expiration date of your license?** **(Please note: if you have been practicing as a pharmacist after the expiration of your license, the Board may reinstate your license but reserves its authority to pursue disciplinary action against you for practicing on an expired license.)**	☐ **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:	

6. 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

7. CONTINUING EDUCATION RECORD FORM

A total of **30 Continuing Education Credit Hours (CEs)**, obtained within the last two years, are required to be submitted at the time you apply for reinstatement. Provide the CE information in the chart below. **Pursuant to MD. Code Ann., Health Occ. § 1-225, all health practitioners must attest to completing an implicit bias training program approved by the Cultural and Linguistic Health Care Professional Competency Program on their first license renewal after April 1, 2022.**

Two (2) CEs must be live, one (1) CE must be on medication errors. CE is considered "live" if it offers the ability for the participant to have real-time interaction with the presenter, including programs approved by the Accreditation Council for Pharmacy Education (ACPE) that are designated by the letter "L" in the course identification number.

Pharmacists reinstating within their first renewal period **are not** required to submit CEs **if the original license was obtained within one (1) year of graduation.**

Would you like to renew your Maryland Vaccination certification? ☐Yes ☐No

CEs used to renew your Vaccine Certification can also be used to renew your license. **If you are renewing your Vaccine Certification, complete Attachment 2.**

Please add additional pages if you require additional space to enter CEs.

Use the following codes: 1. Live CE; 2. Medication Errors; 3. Vaccine

NAME	LICENSE #	NABP e-PROFILE #

CE Program Name	Provider	Date Hours Taken	ACPE/Board Approval Number	CE Code	# of CE Hours

				TOTAL # OF HOURS:	

I affirm under penalty of perjury that the information I have given on this continuing education record is true and correct to the best of my knowledge and belief.

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:	

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?**	☐ **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 PHARMACIST LICENSURE
NEW OR FOREIGN GRADUATES

ATTACHMENT 1

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 the 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.	

APPLICATION FOR PHARMACIST LICENSURE REINSTATEMENT

ATTACHMENT 2

VACCINE CERTIFICATION RENEWAL FORM

Please print clearly in ink or type in uppercase letters only.

NAME	DATE	LICENSE NUMBER

CPR Certification

A Current CPR Certification card is required. Please attach a copy of the CPR card (front and back) to this application. The certification must be obtained through in-person classroom instruction.

Copy of CPR Card attached to this application?	☐**YES** ☐**NO**

Continuing Education Credit Hours (CEs)

The four (2) hours needed to renew your Vaccine Certification may count towards the 30 total CEs required to renew your license.

CE Topic	CE Program Name	ACPE Number	# of Credits	Date

I affirm under penalty or perjury, that the information I have given on this record is true and correct to the best of my knowledge and belief.

Applicant's Signature:	

Date:	