# PHARMACY TECHNICIAN REGISTRATION APPLICATION INSTRUCTIONS – REINSTATEMENT

This application should be completed by pharmacy technicians who want to reinstate their Maryland Pharmacy Technician Registration after it has expired in accordance with Md. Code Ann., Health Occ.COMAR10.34.34.10.

- Complete the attached Maryland Board of Pharmacy's **Application for Pharmacy Technician Registration-Reinstatement**

- **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 $ 45.00 . Please make sure the money orders/checks are signed before submitting to:**:

**Maryland Board of Pharmacy, P.O. Box 2013, Baltimore, MD 21203-2013.**

- **Incomplete checks or money orders will be returned**

- Applications sent overnight or through priority mail must be sent to:

**Wells Fargo Bank, Attn: State of MD – Board of Pharmacy, 401 Market Street, Philadelphia, PA 19106**

**Effective 05/24/2024: applications are to be mailed to Wells Fargo Bank, Attn: State of Maryland Board of Pharmacy, Lock Box 2013, 2005 Market Street, Philadelphia, PA 19103-7042**

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

- Working as a pharmacy technician without an active registration is a violation of the law which may result in disciplinary action by the Board of Pharmacy.

- For reinstatement you are required to complete 20 Continuing Education Credit Hours (CEs).

- **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.**

- If you are applying for reinstatement more than 2 years after expiration of your registration, you must pass a Board-approved examination and provide documentation to the Board. This application is valid for one year from the date received by the Board. If you have not mt the criteria for registration within one year, your application will expire and you will have to submit a new application and fees. Fees paid for expired applications will not be refunded or credited.

- Once you have completed the reinstatement process you will receive a registration form in the mail. Please allow one to two weeks for processing of your reinstatement application.

- To view and track continuing professional education credits from ACPE-accredited providers, all pharmacy technicians should obtain a 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 CE programs must have been approved by Board and may not be retrieved from the CPE Monitor system.)

**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.dhmh.maryland.gov/pharmacy

# APPLICATION FOR PHARMACY TECHNICIAN REGISTRATION – REINSTATEMENT

| ☐ TOTAL FEE PAID: $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.**

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

| 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. EMPLOYMENT 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.

| Employer Name | Dates of Employment | Address & Telephone # |
|---|---|---|
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*Revised 04/30/2024*

## 3. REGISTRATION HISTORY

Indicate registration/licensure information about all current and previously held (or applied for) registrations/licenses to practice as a pharmacy technician. Attach additional sheets if needed. **Submit a written explanation of any registration/license that is not in good standing**.

| | |
|---|---|
| **Have you applied for registration/licensure in any other state?** | ☐YES ☐NO |

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

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

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

## 4. PERSONAL ATTESTATION QUESTIONS

**Please read this section carefully and answer the following questions related to your practice as a pharmacy technician. 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. Please answer the following question based on information from the current registration period only.**

| | |
|---|---|
| **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 technician 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 have a physical or mental condition that may impair your ability to practice pharmacy?** | ☐YES ☐NO |
| **10.** | **Has your ability to practice as a pharmacy technician been affected by the use of any type of drug or alcohol?** | ☐YES ☐NO |
| **11.** | **Have you practiced as a pharmacy technician during the expiration of your pharmacy technician registration?**<br><br>**(Please note that if you answer "yes" to this question, the Board reserves its authority to pursue disciplinary action against your registration for practicing without an active registration after it issues your reinstated registration.)** | ☐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 registered, I agree to practice pharmacy in accordance with the laws of Maryland.**

| | |
|---|---|
| **Signature:** | |
| **Date:** | |

## 5. CONTINUING EDUCATION RECORD FORM

For reinstatement you are required to complete 20 Continuing Education Credit Hours (CEs). 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.**

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

| NAME | LICENSE # | NABP e-PROFILE # |
|---|---|---|
| | | |

| CE Program Name | Provider | Date Hours Taken | ACPE/Board Approval Number | # of CE Credit Hours |
|---|---|---|---|---|
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| | | | | |
| | | | 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.**

| | |
|---|---|
| **Applicant's Signature:** | |
| **Date:** | |

| | |
|---|---|
| **Would you like to receive license renewal notification via email?** | |
| **Would you like to be an emergency preparedness volunteer?** | |

**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:** | |

## 6. 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 |
|---|---|---|
| | | |
| | | |
| | | |

| **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. |

| | | |
|---|---|---|
| **SEX:** | ☐MALE ☐FEMALE | |
| **RACE:** | **Are you of Hispanic or Latino origin?**<br>(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.)** | ☐ |