**PHARMACY TECHNICIAN TRAINING**

**PROGRAM AND EXAMINATION APPLICATION**

**Name of Pharmacy Technician Training Program:**

1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Program Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(*contact person*)**

**Telephone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax#**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **A copy of the course instructions attached. Yes \_\_\_\_ No \_\_\_\_**

1. **A copy of the course outline and syllabus attached. Yes \_\_\_\_ No \_\_\_\_**
2. **A copy of course training materials attached. Yes \_\_\_\_ No \_\_\_\_**

**Examination requirements:**

**The program examination must have a minimum of 100 questions, multiple choice, plus 50 additional questions. The examination must be rotated twice a year.**

1. **A sample examination and answer key attached. Yes \_\_\_\_ No \_\_\_\_**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**ATTESTATION:**

 **I attest that I have read and understand Health Occupations Article 12-6B and COMAR 10.34.34 which governs the practice of Registered Pharmacy Technicians in Maryland and COMAR 10.34.34.06 and .07 which governs the Standards for Pharmacy Technician Training Programs and Standards for Examination Approval in Maryland. I take full responsibility for the program meeting the standards required by the Maryland Board of Pharmacy.**

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 **Program Director’s Signature** **Telephone #** **Date**

 **(*contact person)***

# PHARMACY TECHNICIAN TRAINING PROGRAM

**AND EXAMINATION APPLICATION**

**General Instructions**

To apply for approval of a training program or a non-national\* technician examination, the approval application must be completed and returned to the Board along with:

1. A copy of course instructions
2. A copy of the course outline
3. A copy of course training materials
4. A sample examination, which should include:
	1. ***Content criteria set forth in COMAR Regulation 10.34.34.06*** *(see attached below****)***
	2. ***A minimum of 100 multiple choice questions***
	3. ***Fifty additional questions so that the examination questions may be rotated twice a year; and***
	4. ***Indicates a passing score of 75 percent or higher***
5. Examination answer key
6. Fee of $100.00

The program should be no longer than 6 months duration and should include 160 hours of work experience.

Mail the completed application and all required documents to:

ATTN: Technician Training Program Review

Maryland Board of Pharmacy

 P.O. BOX 2051

 Baltimore, MD 21203-2051

Application Revised 03/2016****