

PHARMACY TECHNICIAN REGISTRATION APPLICATION INSTRUCTIONS

This application should be completed by applicants who want to register as Pharmacy Technicians in Maryland accordance with Md. Code Ann., Health Occ §12-6B-01 – 14.

- Complete the attached Maryland Board of Pharmacy's **Application for Pharmacy Technician Registration**.
- **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 check or money orders will be returned

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

**Wells Fargo Bank, Attn: State of MD – Board of Pharmacy, Lockbox 2013
401 Market Street,
Philadelphia, PA 19106**

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

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

- Request a State of Maryland Criminal History Record Report from the Criminal Justice Information System ("CJIS") and CJIS will provide the report to the Board. Please do not include your CJIS report with the application.
- To contact Maryland CJIS, please call 1.888.795.0011 or 410.764.4501. Our CJIS authorization number is 0600062013. You will need this authorization number when you get fingerprinted

NOTE: Your application will not be processed until the Board receives your completed CJIS report. Please review the in-depth CJIS instructions located on the Board's website at <http://www.dhmh.maryland.gov/pharmacy> by clicking on the "Technician" tab and opening the Word document under general information.

- **Nationally Certified Applicants** must submit evidence of current certification by a national pharmacy technician certification program (legible photocopy of the certificate).
- **Non-Nationally Certified Applicants** must submit evidence of completion of a Board-approved pharmacy technician training program that includes 160 hours of work experience (including the signature of the registrar, pharmacy trainer, and/or pharmacy manager) and evidence of having passed a Board-approved technician examination (legible photocopy of documentation showing program completion and a passing score).
- **Reciprocity Applicants** must submit evidence of registration in another state under requirements similar to the registration requirements in Maryland (legible photocopy of state registration) and a letter of good standing from the state Board in the state(s) of current registration. If your state does not require registration/licensure of pharmacy technicians with the

board of pharmacy, you must submit a Pharmacy Work Experience Affidavit (Attachment 1) completed by the pharmacist under whom you worked as a pharmacy technician for at least six months preceding the pharmacy technician application date to the Maryland Board of Pharmacy.

- **All applicants** must be currently enrolled in high school, be a high school graduate, or have a GED.
- 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.
- 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: Please allow one to two weeks for processing of your application.

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.dhmf.maryland.gov/pharmacy



APPLICATION FOR PHARMACY TECHNICIAN REGISTRATION

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: \$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.

I certify that this is a photograph of me taken within the previous 180 days of submitting this application.

Applicant's Signature: _____

1. IDENTIFICATION

First Name:							
Middle / Maiden Name:							
Last Name:							
Social Security Number: (require copy of proof)							
Street Address:							
City:				State:			Zip:
Home Phone:							
Work Phone:							
Cell Phone:							
Date of Birth:				Place of Birth:			
Email Address: (Required)							

VETERANS AND SPOUSAL PREFERENCE

Are you an active service member of the spouse or an active service member?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
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2. EMPLOYMENT INFORMATION			
Employer Name	Date of Hire	Address	City, State, Zip

3. CERTIFICATION OR TRAINING INFORMATION			
Name of National Certification Program	Certification Number	Date of Certification	Expiration Date
Is your certification in good standing?		<input type="checkbox"/> YES <input type="checkbox"/> NO	
If no, please provide an explanation:			

OR

Name of Board Approved Training Program	Supervisor and Title	Date of Completion
Did you pass an examination approved by the Board?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Did you complete 160 hours of work experience as required by Maryland law?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Permit Holder or Designee Signature:	_____	
Title:		
Date:		

4. EDUCATION INFORMATION			
Name of High School/GED:			
Street Address:			
City:	State:	Zip Code:	
Have you graduated or received your GED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Graduation/GED: (month/year)	
Are you currently enrolled in high school?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
If YES, please submit evidence that you are a student in good standing.			
Expected date of graduation:			

5. REGISTRATION / LICENSURE HISTORY
<i>(For Reciprocity applicants: If your state does not require Pharmacy Technician Registration, please complete Attachment 1)</i>

Have you applied for registration/licensure in any other state?		<input type="checkbox"/> YES <input type="checkbox"/> NO
<i>If YES, disclose all places, dates and results below. Attach additional sheets if necessary.</i>		
Name of State	Date	Registration / License Issued?
		<input type="checkbox"/> YES <input type="checkbox"/> NO
Date Licensed	Registration/License Number	In Good Standing?
		<input type="checkbox"/> YES <input type="checkbox"/> NO
Name of State	Date	Registration / License Issued?
		<input type="checkbox"/> YES <input type="checkbox"/> NO
Date Licensed	Registration/License Number	In Good Standing?
		<input type="checkbox"/> YES <input type="checkbox"/> NO

6. 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.

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.	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you surrendered or failed to renew a healthcare registration or license in any state?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Have you ever withdrawn your application for a technician registration or other health professional license?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Has your employment by any pharmacy, clinic, healthcare practice, or wholesale drug distributor been terminated for disciplinary reasons?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Have you committed a criminal act for which you pled guilty or nolo contendere (see <i>definition below</i>), or for which you were convicted or received probation before judgment?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. Do you have a physical or mental condition that may impair your ability to practice as a pharmacy technician?	<input type="checkbox"/> YES <input type="checkbox"/> NO
10. Has your ability to practice as a pharmacy technician been affected by the use of any type of drug or alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> 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 laws of Maryland.

Signature:	_____
Date:	

7. STATE CRIMINAL HISTORY RECORDS CHECK	
I affirm that I submitted a request for a State Criminal History Records Check on:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Applicant's Name:	
Applicant's Signature:	_____
Date:	

8. 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

9. APPLICATION CHECKLIST	
Application Fee	<input type="checkbox"/> YES <input type="checkbox"/> NO
Recent Photograph	<input type="checkbox"/> YES <input type="checkbox"/> NO
Proof of National Certification (if applicable)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Proof of Social Security Number, Passport or Work VISA card (Required)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Proof of Passing Board-Approved Examination (if applicable)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Proof of State Registration and Good Standing (if applicable)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pharmacy Technician Work Experience Affidavit (if applicable)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Birth Certificate or Other Proof of Birth Date	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you completed your MD state background check	<input type="checkbox"/> YES <input type="checkbox"/> NO
Would you like to receive license renewal notification via email?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Would you like to be an emergency preparedness volunteer?	<input type="checkbox"/> YES <input type="checkbox"/> 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 registration.	
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.

SEX:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
RACE:	<table border="1"> <tr> <td> Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) </td> <td align="center"> <input type="checkbox"/> YES <input type="checkbox"/> NO </td> </tr> </table>	Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)	<input type="checkbox"/> YES <input type="checkbox"/> NO		

<i>If you are not of Hispanic or Latino origin, select one or more of the following racial categories:</i>	
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.)	<input type="checkbox"/>
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.)	<input type="checkbox"/>
3. Black or African American (A person having origins in any of the black racial groups of Africa.)	<input type="checkbox"/>
4. Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)	<input type="checkbox"/>
5. White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)	<input type="checkbox"/>

APPLICATION FOR PHARMACY TECHNICIAN RECIPROCITY CANDIDATES

ATTACHMENT 1: PHARMACY TECHNICIAN WORK EXPERIENCE AFFIDAVIT

The pharmacy manager/supervisor/owner of the pharmacy where the pharmacy technician applicant worked as a pharmacy technician must complete this page. **The time period noted in this affidavit must include at least six months experience as a Pharmacy Technician.**

I certify that _____
Name of Pharmacy Technician

worked at the Pharmacy Practice Location _____

from _____ to _____

for a total of _____ hours in the role of a pharmacy technician.

Print Name:	
Print State Pharmacist License Number:	
Print Expiration Date:	
Print Title:	
Print Address of Pharmacy:	
Print Telephone Number of Pharmacy:	
Today's Date:	

I, _____, Supervising Pharmacist, 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.	
State of:	
County or City of	
Signature:	
	A.D., 20_____

IMPORTANT NOTICE: This affidavit must be notarized and submitted with application where appropriate.