



District of Columbia Department of Health
Health Regulation and Licensing Administration
Board of Pharmacy



**PHARMACY TECHNICIAN
APPLICATION
BOARD OF PHARMACY**

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at 1-877-672-2174, Monday through Friday, 8:15 AM to 4:40 PM EST. **A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)**

SECTION 1: REQUESTED LICENSE TYPE/FEEES

<input type="checkbox"/> PT – Pharmacy Technician	\$50.00
<input type="checkbox"/> PT – Pharmacy Technician (Grandfathering)	\$50.00
<input type="checkbox"/> PT – Pharmacy Technician by Reciprocity	\$50.00
<input type="checkbox"/> PTT Pharmacy Technician Trainee (No Fee)	
Total Enclosed	\$ _____.00

Make check or money order payable to DC Treasurer
MAIL TO:
Department of Health
Health Regulation and Licensing Administration
Board of Pharmacy
P.O. Box 37801
Washington, DC 20013

All applicants are required to undergo a Criminal Background Check

Criminal Background Check: For payment and to schedule an appointment, call 1-877-783-4187 or use the following webpage: <http://www.l1enrollment.com/>

HPLA ONLY

Checks \$	Check #	Staff	
\$ _____.00			

SECTION 2: APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 3. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)	

SOCIAL SECURITY NUMBER									

If applicant does not provide a social security number, a sworn affidavit is required.

MM	DD	YYYY
DATE OF BIRTH		

PLACE OF BIRTH

Provide City and State for US birthplace or Country for foreign place of birth.

<input type="checkbox"/> Male	<input type="checkbox"/> Female
GENDER	
Please check the correct box.	

SECTION 3: SUPPORTING DOCUMENTS REQUIRED

Please indicate the supporting documents you have included with this package or requested to be sent to the Board of Pharmacy. Keep a photocopy of all supporting documents for your records.

HPLA ONLY

A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2"), which clearly expose the area from the top of the forehead to the bottom of the chin with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
B.	One (1) clear photocopy of a U.S. government-issued photo ID, such as driver's license, as proof of identity and age of at least 17 years old	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
C.	If applying as a new Pharmacy Technician: Must submit a copy of high school diploma or its equivalent, or has passed a Board approved examination that proves that he or she has achieved competency in the educational skills required to perform the function of a pharmacy technician.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>

D.	If applying as a new Pharmacy Technician (cont.): Obtain a current certification from: The Pharmacy Technician Certification Board (PTCB); The National Health career Association (formerly ICPT); state certifying organization approved by the Board, or complete a Board approved pharmacy technician training program.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
E.	If applying as Pharmacy Technician (Grandfathering): Proof that applicant has worked as a pharmacy technician as full-time or substantially full-time for at least twenty-four (24) consecutive months immediately prior to <u>11/20/2015</u>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
F..	If applying as Pharmacy Technician (Grandfathering) (cont.): A letter from a licensed pharmacist or pharmacists who has supervised the applicant for at least 6 months immediately prior to <u>11/20/2015</u> attesting the applicant has competently performed the functions of a pharmacy technician	YES <input type="checkbox"/>	NO <input type="checkbox"/>
G..	If applying as Pharmacy Technician by reciprocity: Proof of current licensure, registration, or certification, in good standing to practice as a pharmacy technician in another state	YES <input type="checkbox"/>	NO <input type="checkbox"/>
H.	If applying as Pharmacy Technician by reciprocity: Verification from each state in which the applicant holds or has ever held a pharmacy technician registration, that the registration is current and in good standing, or if the registration is no longer active, that it was in good standing immediately prior to its expiration. The registration verification form must be sent directly to the Board, by the verifying board	YES <input type="checkbox"/>	NO <input type="checkbox"/>
I.	If applying as Pharmacy Technician Trainee: Document showing enrollment in Board-approved pharmacy technician training program or employed as pharmacy technician trainee	YES <input type="checkbox"/>	NO <input type="checkbox"/>
J.	If applying as Pharmacy Technician Trainee: Letter from pharmacist showing that a Pharmacy Technician Trainee shall perform duties that commensurate with the training and experience he or she has received	YES <input type="checkbox"/>	NO <input type="checkbox"/>
K	If an applicant does not have a social security number , then the applicant must submit a sworn affidavit, under penalty of perjury, stating that he or she does not have a social security number	YES <input type="checkbox"/>	NO <input type="checkbox"/>
L.	If an applicant does not have a social security number , then the applicant must submit proof acceptable to the Board that he or she is legally authorized to be in the United States, such as a Certificate of Citizenship or Naturalization, Resident Alien Card, a valid foreign passport with a visa, or a work permit card from the Department of Homeland Security (I-766 or I-688B)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
M.	If applicant's name has changed at any point since first attendance of high school, college or university, then the applicant must also provide a copy of legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders	YES <input type="checkbox"/>	NO <input type="checkbox"/>
N.	Each new applicant shall obtain a criminal background check	YES <input type="checkbox"/>	NO <input type="checkbox"/>

SECTION 4: PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX (Jr, Sr, etc.)

SECTION 5A: HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

APARTMENT SUITE FLOOR PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE ZIP CODE + 4

HOME PHONE NUMBER HOME FAX NUMBER

SECTION 5B: WORK ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME

APARTMENT SUITE FLOOR PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY STATE ZIP CODE

BUSINESS PHONE NUMBER BUSINESS FAX NUMBER

SECTION 5C: PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

HOME BUSINESS

SECTION 6A: SCHOOLS/COLLEGES ATTENDED

List all schools that you have attended, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certificate

Section 6C: LICENSES IN OTHER STATES/JURISDICTIONS

List all states and jurisdictions in which you have ever held a license. Provide letters of verification from original and current jurisdictions (if different).

Jurisdiction	Date License Was First Obtained	License Number

SECTION 7: QUESTIONS – APPLICANTS MUST ANSWER ALL OF THE FOLLOWING QUESTIONS.

Please answer all of the following questions by placing an “X” in the appropriate boxes. If you answer “Yes” to questions B through K below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this application.

HPLA ONLY

A. Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER “YES” TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

[] Yes [] No

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or
6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?

The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).

YES NO

B.	Have you ever been arrested or convicted of a crime or misdemeanor (other than minor traffic violations)?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
C.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
D.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
E.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

F.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
G.	Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
H.	Has any authority taken adverse action against your license?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
I.	Are you currently under investigation or were you investigated by any authority for any violation of state, federal, or local law?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
J.	Has any authority informed you of any pending charges(s) or investigation not previously reported to this Board?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
K.	Have you ever been terminated or asked to resign from employment since obtaining your license?	YES NO <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

SECTION 8: REGISTRANT AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties

<hr/> REGISTRANT SIGNATURE	<hr/> NAME (Please Print)	<hr/> DATE	HPLA ONLY <input type="checkbox"/>
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REPORT FRAUD, WASTE, AND ABUSE: To report fraud, waste, or abuse within the District government, contact the DC Office of the Inspector General’s hotline by phone at 1-800-521-1639 (toll free) or 202-724-TIPS (8477), by email at hotline.oig@dc.gov, or by TTY at 711. For additional information, visit the Office of the Inspector General’s website at oig.dc.gov.