



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



**NEW LICENSE 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 (includes non-refundable application fee – see instructions)			
<input type="checkbox"/>	PH – Pharmacist by Examination	\$280.00	Make check or money order payable to <u>DC Treasurer.</u> MAIL TO: Department of Health Health Regulation and Licensing Administration Board of Pharmacy P.O. Box 37801 Washington, DC 20013
<input type="checkbox"/>	PH – Pharmacist by Reciprocity	\$280.00	
<input type="checkbox"/>	PH – Pharmacist by Reciprocity w/ Waiver of Licensure Transfer	\$280.00	
<input type="checkbox"/>	PH – Score Transfer	\$280.00	
<input type="checkbox"/>	MPJE Jurisprudence District Re-examination / NAPLEX	\$85.00	
<input type="checkbox"/>	PHI – Pharmacy Intern U. S. Students	\$50.00	
<input type="checkbox"/>	PHI – Pharmacy Foreign Students	\$50.00	
<input type="checkbox"/>	VAC – Vaccination and Immunization Agent	\$50.00	
<input type="checkbox"/>	DC License Pharmacist- Adding VAC authority DC PH license number PH _____	\$50.00	
<input type="checkbox"/>	Duplicate Licenses (limit 5) _____ X \$34.00 =	\$ _____.00	
Total Enclosed		\$ _____.00	

HPLA ONLY

Check \$	Check #	Staff
\$ _____.00		

All applicants are required to undergo a Criminal Background Check

Criminal Background Check: For payment and to schedule an appointment, call 1-877-783-4787 or use the following webpage: <http://www.i1enrollment.com/>

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 2. 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.																								
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 30%;"></td> <td style="border-bottom: 1px solid black; width: 5%;"></td> <td style="border-bottom: 1px solid black; width: 50%;"></td> <td style="border-bottom: 1px solid black; width: 10%;"></td> </tr> <tr> <td align="center">FIRST NAME</td> <td align="center">MI</td> <td align="center">LAST NAME</td> <td align="center">SUFFIX (Jr., Sr., etc.)</td> </tr> </table>					FIRST NAME	MI	LAST NAME	SUFFIX (Jr., Sr., etc.)	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black; width: 20%;"></td> <td style="border-bottom: 1px solid black; width: 20%;"></td> <td style="border-bottom: 1px solid black; width: 20%;"></td> <td style="border-bottom: 1px solid black; width: 20%;"></td> <td style="border-bottom: 1px solid black; width: 20%;"></td> </tr> <tr> <td align="center">MM</td> <td align="center">DD</td> <td align="center">YYYY</td> <td colspan="2"></td> </tr> <tr> <td align="center" colspan="5">DATE OF BIRTH</td> </tr> </table>						MM	DD	YYYY			DATE OF BIRTH				
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SECTION 3. SUPPORTING DOCUMENTS REQUIRED			HPLA ONLY
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.			
A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies. RE-EXAM APPLICANTS ARE NOT REQUIRED TO SUBMIT PHOTOS.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
B.	If applying by Examination: Official transcript (with seal) showing successful completion of an educational program in the practice of pharmacy and holds a Bachelor of Science or Doctorate of Pharmacy degree from a School of Pharmacy accredited by the American Council of Pharmaceutical Education (ACPE). May be sent directly from the school, but is preferred that it accompany the application in a sealed envelope.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Applicants taking the North American Pharmacist Licensing Examination (NAPLEX) or Multistate Pharmacy Jurisprudence Examination (MPJE) exam need to submit their information directly to National Associations of Boards of Pharmacy (NABP) with the appropriate exam fees.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
D.	Foreign applicant applying for Internship must submit Foreign Pharmacist Graduate Examination Certificate.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION**

NEW LICENSE APPLICATION

E.	Score Transfer applicants must have requested to have their score transfer sent directly to the District of Columbia at the time they applied to sit for the NAPLEX and must have results sent directly to the District of Columbia Board of Pharmacy.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
F.	Reciprocity Applicants: Licensure transfer report must have been requested from the National Associations of Boards of Pharmacy (NABP).	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
G.	Reciprocity by Waiver of Licensure Transfer Applicants: Provide current verification of licensure from another state Board of Pharmacy.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
H.	If applying for or adding a VAC authority , you must provide proof of a successful completion of a ACPE certification course approved by the Board of Pharmacy and provide a copy of CPR Certification for Healthcare Professionals.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
I.	As of January 3, 2011, each new applicant for licensure, registration or certification shall obtain a criminal background check.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
J.	Are you a Pharmacy intern registering for the sole purpose of completing an IPPE or APPE? If so, you are not required to provide documentation of a preceptor or to notify the Board when the pharmacy intern changes preceptors or worksites.	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
K.	Preceptor Form required for any pharmacy intern working in a District of Columbia pharmacy outside of the structured program of an IPPE or APPE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)

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

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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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

<input type="text"/>	<input type="text"/>	<input type="text"/>
STATE	ZIP CODE + 4	

<input type="text"/>	<input type="text"/>	<input type="text"/>
HOME PHONE NUMBER	HOME FAX NUMBER	EMAIL ADDRESS

Section 5B. BUSINESS 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)

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH PROFESSIONAL LICENSING ADMINISTRATION**

NEW LICENSE APPLICATION

CITY _____
 BUSINESS PHONE NUMBER _____

STATE _____ ZIP CODE _____
 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. PROFESSIONAL SCHOOLS 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 6B. POSTGRADUATE WORK EXPERIENCE

List all work experience since graduation from college, university and professional school, in reverse chronological order, beginning with the most recent.

Organization/Institution	Location	Start Date	End Date	Type of Position (Use Key Below)*	Full Time	Part Time

- * TYPE OF POSITION KEY
 A. Employment
 B. Private Practice
 C. Clinical Rotation
 D. Instructor
 E. Internship
 F. Other (specify on separate sheet of paper)

Section 6C. PROFESSIONAL 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

NEW LICENSE APPLICATION

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 J 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 <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Are you now or have you ever been licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete section 6C of this form.)	YES <input type="checkbox"/>	NO <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 <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
E.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
F.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
G.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
H.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
I.	(1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
J.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>

SECTION 8. LICENSEE 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.

**HPLA
ONLY**

LICENSEE SIGNATURE

NAME (Please Print)

DATE

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.