STATE OF MAINE
BOARD OF PHARMACY

Applicant information to assist in completing your application

Pharmacist by Examination/Score Transfer

Do not return the following informational pages with your application; it is for your information only

Department of Professional and Financial Regulation
Office of Licensing and Registration
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603
TTY/Hearing Impaired 1-888-577-6690
FAX (207) 624-8637
Web address: www.maine.gov/professionallicensing
Email: pharmacy.lic@maine.gov

APPLICATION INSTRUCTIONS
PHARMACIST

The following is a guideline to assist in your application process. It does not, however, replace the requirements outlined in the Board of Pharmacy Laws and Rules. Please review them carefully for more detailed and clarifying information.

- To register for the NAPLEX and the Multi-State Pharmacy Jurisprudence Examination, go to http://www.nabp.net/ . Please note if you are applying by score transfer, the score is valid for one year only from date of passing NAPLEX examination.

- You must provide evidence of having completed a minimum of 1,500 internship hours.

- Your NAPLEX, Score Transfer and MPJE score results are reported directly by electronic means to the Maine Board, which in turn will be reported to you in writing. **Please allow at least 10 days.** Please do not call our office for your results. Scores will not be released by phone.

- All Foreign pharmacy graduates must submit the FPGEC issued by NABP. You must submit the appropriate certification evidence issued by NABP with this application. Please visit the NABP website for information on the FPGEE process and to contact NABP http://www.nabp.net/ . We cannot help you on this matter.

- Official transcripts of your pharmacy degree must accompany your application.

- You must demonstrate that you are at least 21 years of age. A copy of your official birth certificate or other official legal document is acceptable.

- If you hold or have held a pharmaceutical license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.

- If you have a disability and require special accommodations in taking the examination, please complete the enclosed "request for accommodation" form and submit it with your application. The Maine Board of Pharmacy outsources all examination administrations. Special accommodation request must be submitted well in advance of the test date, we cannot guarantee the availability of accommodations on-site.

- MULTISTATE PHARMACY JURISPRUDENCE EXAM (“MPJE™”) References: The Maine Pharmacy laws and rules, Department of Public Safety rules on security prescription blanks, and pharmacy related federal regulations are accessible online at www.maine.gov/professionallicensing Click on “professions and occupations” under “About this Board” click on “laws and rules.” You may also contact the following agency for federal regulations: U.S. Government Printing Office Tel (202) 512-1800, at the following web site: www.access.gpo.gov/nara/cfr/cfr-table-search.html

- Not all pages of this application contain your name, please place your initials on pages where noted.

INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED. Be sure to initial the bottom of each page where noted on your application. This is critical to insuring that each page of your application is intact with the correlating application and will help us with expediting your application review.

The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

PROCESSING TIME:

- ✓ Please allow approximately three (3) weeks processing time from date of receipt.
- ✓ Please do not call our office regarding the status of your application as numerous calls will delay the timeliness of processing applications. Information regarding the status of applications may be found at the Office of Licensing and Registration's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.
- ✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are printed off site and require at least 14 days for delivery.

VERIFICATION OF LICENSURE

If you hold or have held a pharmaceutical license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.

Please contact the state of licensure to request an official License Verification. At a minimum, the license verification must contain:

- Name of State providing the License Verification
- Your name
- License number and expiration date
- Status of your license i.e. active, inactive, lapsed, probation, restricted, suspended, revoked…
- Type of license issued to you
- Date your license was issued
- If appropriate, hours of internship completed with beginning and ending dates
- Method your license was issued i.e. Original State, Reciprocity/Endorsement, Score Transfer
- Examinations taken i.e. NAPLEX, Jurisprudence, other
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing jurisdiction providing License Verification
- State Seal

Please direct the licensing jurisdiction to send the License Verification report to you directly and in turn you must submit this verification with your completed Maine application.

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number Is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) *or* credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF LICENSING AND REGISTRATION
INDIVIDUAL LICENSE APPLICATION

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME	FIRST	MIDDLE INITIAL	LAST
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH mm / dd / yyyy		SOCIAL SECURITY NUMBER - -	
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )	E-MAIL	

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

1. **Have you ever been convicted by any court of any crime? (circle one) NO YES**

   If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.

2. **Has any jurisdiction (including Maine) taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one) NO YES**

   If yes, enclose a detailed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Licensing and Registration will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE **DATE**

BOARD OF PHARMACY
PHARMACIST LICENSE

By EXAMINATION - Required Fee: $221.00

By SCORE TRANSFER - Required Fee: $121.00

Optional Certification of Administration of Drugs and Immunizations Available

(includes examination processing and criminal record check)

LICENSE TYPE:

☐ PHARMACIST by EXAMINATION (*PR1447*) *$221.00*

☐ PHARMACIST by SCORE TRANSFER (*PR1447*) *$121.00*

☐ CHECK HERE IF ADDING OPTIONAL CERTIFICATION OFADMINISTRATION OF DRUGS AND IMMUNIZATIONS

Office Use Only:

BY EXAM
PR 1447 - $200.00
2619 - $21.00

BY SCORE TRANSFER
PR 1447 - $100.00
2619 - $21.00

Office Use Only:

Check #______________
Amount:______________
Cash #______________
Lic. #______________
Issue Date____________
Exp. Date____________

PAYMENT OPTIONS:

Make checks payable to “Maine State Treasurer” - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print) FIRST MIDDLE INITIAL LAST

I authorize the Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my

☐ VISA ☐ MASTERCARD the following amount: $____________

Card number: XXXX-XXXX-XXXX-XXXX Expiration Date mm / yyyy

SIGNATURE **DATE**

SECTION 1: INTERNSHIP

You must submit evidence of having completed 1,500 hours of internship training.
☐ Evidence from the college where I completed a pharmacy degree program.
☐ Signed affidavit(s) from Preceptor(s).
☐ Certification by a state pharmacy licensing board where these hours were reported.

SECTION 2: EDUCATION

Please check all that apply:
☐ American Council on Pharmaceutical Education (ACPE)
☐ Canadian Council for Accreditation of Pharmacy Programs (CCAP)
☐ Foreign Pharmacy Graduate
☐ FPGEC

College of Pharmacy		Date of Graduation
Contact Address	PO BOX or Street Address	
City	State	Zip
Official transcripts demonstrating your degree must be submitted with your application.		

________ INITIALS OF APPLICANT

SECTION 3: LIST BELOW EVERY JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PHARMACY LICENSE. Includes pharmacy technician, pharmacy intern or pharmacist license or registration. List each state in which you hold or have ever held a pharmacy technician, pharmacist or pharmacy intern license or registration.

1. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
4. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date

Use a separate sheet of paper if additional space is needed.

NOTE: For each of the above, you must submit with this application an official Verification of Licensure from **each** licensing jurisdiction. **IMPORTANT:** Applications submitted without **all of the Verifications of Licensure** from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

SECTION 4: Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

Question	Response
Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or has this entity ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked this entities state permit to prescribe or dispense controlled substances? If yes: 1. DEA action OR Other Entity (Name) _______________ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper.	☐ Yes ☐ No
Have you ever received a sanction from Medicare or from a state Medicaid program? 1. ☐ Medicare OR ☐ Medicaid Program (State) ____________ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper.	☐ Yes ☐ No

________ INITIALS OF APPLICANT

SECTION 5: CERTIFICATE OF ADMINISTRATION OF DRUGS AND IMMUNIZATIONS
YOU MUST COMPLETE SECTION A, B OR C, WHICHEVER APPLIES.

SECTION A: Currently authorized by another jurisdiction to administer drugs and immunizations and your training or course work is compliant with 32 MRSA § 13832(4). (See insert in gray section below).

Are you currently authorized/licensed by any jurisdiction to administer drugs and immunizations?
☐ Yes or ☐ No List State:_______________.

Do you have continous administration practice since completion of training in drug administration? (32 MRSA § 13832(4) ☐ Yes or ☐ No

Has any adverse disciplinary action been taken against this authorization/license? ☐ Yes or ☐ No

Please submit a license verification from the licensing jurisdiction to verify that you are authoritized to administer drugs and immunizations.

If you are not currently certified/licensed in another jurisdiction and qualify with educational licensing, please complete section B or C, whichever applies.

For Section B or C

Your PharmD transcripts or evidence of having completed a 20 hour course of study **must** accompany this application; otherwise your application will be deemed incomplete and returned without processing. The PharmD program or the 20 hour course of study must meet the didactic & practical requirements described in 32 MRSA § 13832(4).

32 MRSA § 13832(4)
Didactic; practical course. Satisfactorily complete a didactic and practical course approved by the board that includes the current guidelines and recommendations of the federal Department of Health and Human Services, Centers for Disease Control and Prevention, the American Council on Pharmaceutical Education or a similar health authority or professional body, and that includes, but is not limited to, disease epidemiology, indications for use of vaccines, vaccine characteristics, injection techniques, adverse reactions to vaccines, emergency response to adverse events, immunization screening, informed consent, record keeping, registries, including the immunization information system established under Title 22, section 1064, registry training and reporting mechanisms, including reporting adverse events, life support training, biohazard waste disposal and sterile techniques and related topics.

Pursuant to 32 MRSA Sub-Section 13832(3) training must have been obtained within 3 years immediately preceding this application. In addition:
- A PharmD transcript must clearly state your name and date the degree was awarded.
- The 20 hour course of study must clearly state your name, date of completion and the number of hours completed.

SECTION B: TRAINING - Complete this section IF APPLYING BY HAVING COMPLETED A 20-HOUR COURS OF STUDY (32 MRSA §13832, section 3)

Please list the name of the course, the course sponsor and date course completed.

☐ Check here if this is an *American Council on Pharmaceutical Education (ACPE)* course.

Course name:____

Date Completed:_____________________

☐ Check here if this is a course sponsored or approved by the *Centers for Disease Control and Prevention*.

Course name:____

Date Completed:_____________________

☐ Check here if *Other*: - please provide a copy of the course syllabus or course content.
Course sponsor:____

Course name:____

Date Completed:_____________________

________ INITIALS OF APPLICANT

SECTION C: TRAINING - Complete this section if applying with a PharmD degree.

College of Pharmacy		Date degree awarded
College Contact Address	PO BOX or Street Address	
City	State	Zip

SECTION D: LIFE SUPPORT TRAINING (CPR) — Evidence of completing cardiovascular life support training.

Please complete the following.

☐ Check here if this is an *American Heart Association* course.

Course name:____

Date Completed:________________________

☐ Check here if this is an *American Red Cross* course.

Course name:____

Date Completed:________________________

☐ Check here if *Other*:

Course sponsor:____

Course name:____

Date Completed:________________________

SECTION E: **For Your Information on Treatment Protocol**

The following is an excerpt from 32 MRSA §13833:

"The pharmacist shall administer drugs and immunizations in compliance with a treatment protocol established by a practitioner authorized under the laws of this State to order administration of those drugs and immunizations approved by the board. A copy of the treatment protocol must be submitted to the board…."

BOARD RULE CHAPTER 4-A

Requires a pharmacist holding a certificate of administration or the pharmacy or pharmacies to which the treatment protocol is issued shall submit a copy of the protocol to the board no later than 20 calendar days after the effective date of the protocol.

________ INITIALS OF APPLICANT

SECTION 6: NOTICES

Healthcare Integrity and Protection Data Bank ("HIPDB") Self-Query Reports – this is required for issuance of your license.

In accordance with 10 MRS §8003(10), all applicants must submit a NPDB/HIPDB Self-Query Report as part of the initial application for licensure. The instructions to request a self-query report are available at HIPDB's website: www.npdb-hipdb.hrsa.gov The website includes a Fact Sheet on self-querying, as well as FAQs to assist you in requesting a report. Customer Service Contact information: **NPDB-HIPDB Customer Service Center - Tel: (800)767-6732 - TDD: (703)802-9395**

Public Information

This application is a public record for purposes of Maine's Freedom of Access Law, 1 MRS §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State's website.

10 Day Notification Requirement

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

a. Change of name or address of the licensee;

b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;

c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or

d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRS section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

________ INITIALS OF APPLICANT

SECTION 7: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

The Applicant certifies by his/her signature that the management of the pharmacy will be vested with the licensed pharmacist in all matters directly or indirectly related to the practice of pharmacy or in any matters related to health, welfare, and safety of the public, as required by 32 MRS Section 13752(4).

Applications that are incomplete, altered, defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing supporting documents, and/or missing or wrong fee.

Printed Name of Applicant	Title
Signature of Applicant	Date

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BOARD OF PHARMACY
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8603 – FAX:(207)624-8637

AFFIDAVIT OF INTERNSHIP HOURS

****This form is only to be used if your state does not certify intern hours obtained****

Last Name	First Name	Middle Name

Contact Address (Street or PO Box)

City	State	Zip Code

Intern License Number	State Issued	Expiration Date

Place of Internship - Name of Facility	License Number

Physical Address

City	State	Zip Code

Telephone Number
( )

Preceptor Name	License Number

Hours worked at this site (give only exact dates that this report covers – **not entire work history**)

Beginning Date of this Report	End Date of this Report	Total number of hours worked at this site during the period stated.

The above information was taken from payroll or other records which are kept at the following location(s) and may be examined by an agent of the Board (Give Street Address, City, and State):

I hereby state that the intern named above was trained at the site listed above, worked the hours reported, and practice in accordance with the Board's Laws and Rules. I further understand that I shall be responsible fore certify the practical experience affidavits required by the board of Pharmacy and submit reports on the progress and aptitude of the intern when requested. By submitting this application I understand that the Board of Pharmacy will rely upon this information and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

____
Affirmation and Signature of Preceptor

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AUGUSTA, MAINE 04333-0035
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CERTIFICATE OF MORAL CHARACTER

This form must be completed by the person attesting to the applicant's good moral, ethical and professional character.

The person attesting to the applicant's good moral character must be personally known to him/her and be prepared to furnish additional information concerning the applicant's character, education, and standing as may be requested by the Board of Pharmacy.

I, the undersigned, hereby confer that I am personally acquainted with the applicant named below and know him/her to be of good moral character.

Please write legibly.

Applicant's Name *(Please Print)*		
Name of Person Conferring Applicant's Character	Name	
	Street	
	City/State/Zip	
	Telephone #	Email Address:
	Occupation	Date
	Signature	
Briefly describe how the applicant is known to you. (e.g. fellow colleague, neighbor, long time friend, etc.)		

By submitting this application and supporting documents I understand that the Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

SIGNATURE OF APPLICANT DATE

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ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission.

NAME: ____

ADDRESS: ____

TELEPHONE #: ____________________ SOCIAL SECURITY NUMBER: ____________________

Accommodations Requested for the ________________________ Examination.
Disability ________________________________

<u>Please check all that apply</u>

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
  ☐ Time-and-a-half
  ☐ Double time
  ☐ More than double time (specify): ______________________________
☐ Use of Computer or other adaptive equipment (specify): ______________________________
☐ Other: ____

____

Signed and dated: ____

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DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known ________________________________ **since** ____________________ **in**
(Test applicant) (Date)

my capacity as a ____.
(Professional Title)

This applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, providing the following should accommodate him/ her:
(check all that apply):

☐ Accessible Testing Site
☐ Separate Testing Site
☐ Braille
☐ Large Print
☐ Tape
☐ Reader as Accommodation for Visual Impairment
☐ Scribe/Amanuensis as Accommodation for Visual or Motor Impairment
☐ Reader as Accommodation for Learning Disability
☐ Scribe/Amanuensis as Accommodation for Learning
☐ Sign Language Interpreter
☐ Extended Time
  ☐ Time-and-a-half
  ☐ Double time
  ☐ More than double time (specify): ______________________________
☐ Use of Computer or other adaptive equipment (specify): ______________________
☐ Other:____

Signed: ______________________________ Title: ____________________

Date: ____________________ License # (if applicable): ____________________