



MAINE BOARD OF PHARMACY

Pharmacist by Reciprocity/Endorsement

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

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(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 users call Maine relay 711
FAX (207) 624-8637

Web address: www.maine.gov/professionallicensing
Email: pharmacy.lic@maine.gov

APPLICATION INSTRUCTIONS **PHARMACIST by Reciprocity/Endorsement**

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

- You must demonstrate that you are at least 21 years of age. A photocopy of your official birth certificate or other official legal document is acceptable.
- Official transcripts of your pharmacy degree must accompany your application.
 - 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.
- Applicants must demonstrate the practice of pharmacy for a period of at least one year or must demonstrate 1,500 hours of internship. If a form is required, they accessible online at www.maine.gov/professionallicensing
- When filing your Maine Board of Pharmacy pharmacist by reciprocity/endorsement application you must additionally include the NABP Preliminary Transfer application.
- If you hold or have held a professional license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.
- To register for the Multi-State Pharmacy Jurisprudence Examination, go to <http://www.nabp.net/> . Please note you may register prior to submission of this application.
- If you have a disability and require special accommodations for 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 requests 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 "list of licensed professions", click on "Pharmacy" under "Board of Pharmacy Home" click on "Laws & 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
- Your 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 business days.** Please do not call our office for your results. Scores will not be released by phone.
- In Maine, you must be authorized to Administer Drugs and Vaccines and/or Collaborative Drug Therapy Management by virtue of additional license(s). Applications to apply for an initial Administration of Drugs and Vaccines or Collaborative Drug Therapy Management are available online at www.maine.gov/professionallicensing

Continuing Education:

As a Pharmacist you will be required to satisfy the Continuing Education requirements pursuant to 32 MRS § 13735 and Board Rules Chapter 5. Please be sure to review this information carefully.

PROCESSING TIME.

Your application has a greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the license will be issued and the status will show as ACTIVE.

Please refrain from calling our office to “check” on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation’s website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

IMPORTANT INFORMATION REGARDING YOUR LICENSE: The Office no longer prints

licenses. Upon issuance of your license, you will be notified by email using the email address you provide in this application from noreply@maine.gov that your license has been issued with your license attached to the email (a paper license will not be sent by regular mail). The email with your license will contain the access code that is required to renew your license online when the time comes. You may also update your contact information and email address using this access code, go online to www.maine.gov/professionallicensing.

Approximately sixty (60) days prior to the expiration of your license a courtesy renewal reminder will be sent to you by email. It is important that you maintain a current email on file or risk not receiving the renewal reminder. You do not need to wait for a renewal reminder to renew your license. The online renewal opens sixty (60) days prior to the license expiring and you may renew online anytime.

Your application will be considered incomplete and will be returned if this application is: incomplete, altered (including use of any white out), defaced, or compromised. Examples of an incomplete application include, but are not limited to, unanswered questions requiring a response, lack of appropriate signature, information is illegible and required supporting documents not included.

VERIFICATION OF LICENSURE

If you hold or have held a professional 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.

A sample license verification is available on the Board's website in the applications and forms section.

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.

You may also obtain an electronically produced License Verification directly from the State Board website. For electronic License Verifications please be sure that it contains the State web-address and date the License Verification was printed, and any indication of disciplinary history.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 web: www.maine.gov/professionallicensing

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 emailed 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 Professional and Occupational Regulation 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. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). 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.

SECTION 1: PREVIOUS PHARMACEUTICAL EMPLOYMENT

1. Employer	Position
Beginning Date of Employment	End Date
2. Employer	Position
Beginning Date of Employment	End Date
3. Employer	Position
Beginning Date of Employment	End Date

Attach a separate sheet of paper for additional employment.

Pursuant to 32 MRS §13733 (1)(D) applicants must demonstrate practice within 5 out of the 10 years immediately preceding the application.

SECTION 2: EDUCATION

Please check all that apply:		
<input type="checkbox"/> American Council on Pharmaceutical Education (ACPE)		
<input type="checkbox"/> Canadian Council for Accreditation of Pharmacy Programs (CCAP)		
<input type="checkbox"/> Foreign Pharmacy Graduate <input type="checkbox"/> 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.		

SECTION 3:

Do you hold or have you ever held a professional license? Yes No

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.

IMPORTANT: Any missing verification(s) of licensure will render your application 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.

<p>Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or have you ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances? If yes:</p> <ol style="list-style-type: none"><input type="checkbox"/> DEA action <input type="checkbox"/> Other State or Province (Name) _____Submit a copy of the official action by the entity.Provide a detailed explanation in your own words on a separate sheet of paper.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you ever received a sanction from Medicare or from a state Medicaid program?</p> <ol style="list-style-type: none"><input type="checkbox"/> Medicare <u>OR</u> <input type="checkbox"/> Medicaid Program (State) _____Submit a copy of the official action by the entity.Provide a detailed explanation in your own words on a separate sheet of paper. <p>Clarification on programs:</p> <ul style="list-style-type: none">Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease.Medicaid – Health program administered by the United States government for people with limited incomes.MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 5: NOTICES

Please Note:

Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.

You can access this Law for your review at:

<http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

DID YOU ENCLOSE THE FOLLOWING:

Please review the list below to ensure you are filing a complete application. If the application is not yet complete, please wait until you have all of the required documentation to submit with this application.

- ◇ Each section of the NABP Preliminary Transfer application is completed.
- ◇ Each page of the Maine Board application is completed.
- ◇ Signature present where noted.
- ◇ Payment in the amount of \$121.00 is enclosed.
- ◇ List of Jurisdictions you are/have been licensed in (*in the format given in section 7*).
- ◇ A signed copy of the consent agreement or order issued by the Board/Jurisdiction if discipline has been indicated.
- ◇ A copy of the Court Judgment and Decision if convicted of a crime, including a signed written statement, in your words, regarding the details of the crime.

SECTION 6: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), 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 required supporting documents, and/or missing or wrong fee.

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.

Printed Name of Applicant	Title
Signature of Applicant	Date
	



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MAINE BOARD OF PHARMACY
35 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0035
TEL:(207)624-8620 – 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 practiced in accordance with the Board's Laws and Rules. I further understand that I shall be responsible for certifying the practical experience affidavits required by the Maine Board of Pharmacy and submit reports on the progress and aptitude of the intern when requested. By submitting this application I understand that the Maine 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

Date

State and License #



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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**)

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Affirmation and Signature of Preceptor _____ Date _____ State and License # _____



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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 personally know him/her and be prepared to furnish additional information concerning the applicant's character, education, and standing as may be requested by the Maine Board of Pharmacy.

I, the undersigned, hereby affirm 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 <i>(Please Print)</i>			
Name of Person Attesting to 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 Maine 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 for 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 _____

Please 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: _____ Date: _____

