California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

PHARMACY TECHNICIAN APPLICATION

Please read the application instructions before you complete the application. Failure to provide the requested information ~~will~~ may result in the application being considered incomplete. Attach additional sheets on paper if necessary.

TAPE A COLOR PASSPORT STYLE 2"X2" PHOTO TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION

NO POLAROID OR SCANNED IMAGES

PHOTO MUST BE ON PHOTO QUALITY PAPER

_____ **Military** (Are you currently serving in the United States military?)
_____ **Veteran** (Have you ever served in the United States military?)

MILITARY EXPEDITE (Please check one of the following, if applicable)

_____**Veteran** (Have you served as an active duty member of the United States military and been honorably discharged?)

_____**Active Duty Military Spouse or Domestic Partner** (Are you married to, or in a domestic partnership or other legal union with, an active duty member of the United States military who is assigned to a duty station in California under official active duty military orders and do you hold a current license in another state, district, or territory of the United States in the profession for which you seek licensure?)

REFUGEE EXPEDITE (Please check one of the following, if applicable)

_____ Refugee pursuant to section 1157 of title 8 of the United States Code;
_____ Refugee granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to section 1158 of title 8 of the United States Code; or,
_____ Refugee with a special immigrant visa that has been granted a status pursuant to section 1244 of Public Law 110-181, Public Law 109-163, or section 602(b) of title VI of division F of Public Law 111-8.

Applicant Information - Please Type or Print

_____ _____ _____
Full Legal Name - Last Name First Name Middle Name

_____
Previous Names (AKA, Maiden Name, Alias, etc.)

_____
*Official Mailing/Public Address of Record (Street Address, PO Box #, etc.) City State Zip Code

_____
Residence Address (If different from above) Street City State Zip Code

_____ _____ _____
Home # Cell # Work #

_____ _____
Driver's License Number State Email Address

_____ _____
Date of Birth (Month/Day/Year) **US Social Security # or Individual Tax ID #

THIS SECTION IS FOR BOARD USE ONLY

App Fee: ___ Enf. Check: ___ Photo: ___ Qualify Code: ____ School Code: _____	FP Card/Fee: ___ LS: ___ DOJ Date__ FBI Date __	**Issuance**	**CASHIERING ONLY**	
		License #	*APPLICATION FEE*	
		Date Issued	Receipt #:	
		Date Expires	Date Cashiered:	
			Amount:	

Mandatory Education
Please indicate how you satisfy the education requirement in Business and Professions Code section 4202(a).

_____ High school graduate or foreign equivalent.
Attach an official embossed transcript or notarized copy of your high school transcript, or certificate of proficiency, or foreign secondary school diploma along with a certified translation of the diploma if it is not in English.

_____ Completed a general education development certificate equivalent.
Attach an official transcript of your test results or certificate of proficiency.

Pharmacy Technician Qualifying Method (check one box)
Please check one of the boxes below indicating how you qualify in order to apply for a pharmacy technician license pursuant to section 4202(a)(1) through ~~(2)(3)~~(4) of the Business and Professions Code.

_____ Attached is the **Affidavit of Completed Coursework or Graduation** for: Associate degree in Pharmacy Technology, Training Course, or Graduate of a school of pharmacy

_____ Attached is a ~~certified~~ copy of PTCB or ExCPT certificate~~ Date certified: _____~~

_____ Attached is a ~~certified~~ copy of military training DD214

List all state(s) where you hold or held a license as a pharmacy technician, pharmacist, intern pharmacist, and/or ~~pharmacy technician and or~~ another health care professional license, including California. Attach an additional sheet if necessary.

State	Registration Number	Active or Inactive	Issued Date	Expiration Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Self-Query Report by the National Practitioner Data Bank (NPDB)
_____ Attached is the original sealed envelope containing my Self-Query Report from NPDB. (This must be submitted with your application.)

~~**You must provide a written explanation for all affirmative answers indicated below. Failure to do so may result in this application being deemed incomplete and being withdrawn.**~~

~~**1.** Do you have a mental illness or physical illness that in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health or safety risks?~~
~~Yes _____ No _____ If "yes," attach a statement of explanation. If "no," proceed to #2.~~

~~Are the limitations caused by your mental illness or physical illness reduced or improved because you receive ongoing treatment or participate in a monitoring program?~~
~~Yes _____ No _____ If "yes," attach a statement of explanation.~~
~~If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing mental illness or physical illness to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for license.~~

~~**2.** Have you previously engaged in the illegal use of controlled substances?~~
~~Yes _____ No_____ If "yes," are you currently participating in a supervised substance abuse program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes _____ No_____ If Yes, attach a statement of explanation.~~

~~**3.** Do you currently participate in a substance abuse program or have previously participated in a substance abuse program in the past five years?~~
~~Yes _____ No_____ If "yes," are you currently participating in a supervised substance abuse program or professional assistance program which monitors you to ensure you are maintaining sobriety?~~
~~Yes _____ No_____ Attach a statement of explanation.~~

~~**4.** Has disciplinary action ever been taken against your designated representative, pharmacist, intern pharmacist and/or pharmacy technician license in this state or any other state?~~
~~Yes _____ No_____ If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.~~

~~**5.** Have you ever had an application for a designated representative, pharmacist, intern pharmacist and/or pharmacy technician license denied in this state or any other state?~~
~~Yes _____ No_____ If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.~~

~~**6.** Have you ever had a pharmacy license, or any professional or vocational license or registration, denied, suspended, revoked, placed on probation or had other disciplinary action taken by this or any other government authority in California or any other state?~~
~~Yes _____ No_____ If "yes," provide the name of company, type of permit, type of action, year of action and state.~~

~~**7.** Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, medical device retailer or any other entity licensed in this state or any other state?~~
~~Yes _____ No_____ If "yes," provide company name, type of permit, permit number and state where licensed.~~

APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS.

Ownership Information - For any affirmative answer, attach a statement of explanation including company name, type of license, license number, and identify the state, territory, foreign country, or other jurisdiction where licensed.

1. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator, or medical director on a license to conduct a pharmacy, wholesaler, third-party logistics provider, or any other entity licensed in any state, territory, foreign country, or other jurisdiction?
   Yes No If "yes," attach a statement of explanation.

Disciplinary History - The following questions pertain to a license sought or held in any state, territory, foreign country, or other jurisdiction. For any affirmative answer, attach a statement of explanation including type of license, license number, type of action, date of action, and identify the state, territory, foreign country, or other jurisdiction.

2. Have you ever had an application for pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration denied?
   Yes No If "yes," attach a statement of explanation.

3. Have you ever had a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it?
   Yes No If "yes," attach a statement of explanation.

4. Have you ever had a pharmacy, wholesaler, third-party logistics provider, and/or any other entity license denied, suspended, revoked, placed on probation, or had other disciplinary action taken?
   Yes No If "yes," attach a statement of explanation.

Practice Impairment or Limitation

The board will make an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the board is unable to make a determination based on the information provided, the board may require an applicant to be examined by one or more physicians or psychologists, at the board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.

5. Do you have an emotional, mental, or behavioral disorder that may impair your ability to practice safely?
   Yes No If "yes," attach a statement of explanation.

6. Do you have a physical condition that may impair your ability to practice safely?
   Yes No If "yes," attach a statement of explanation.

7. Do you have any other condition that may in any way impair or limit your ability to practice safely?
   Yes No If "yes," attach a statement of explanation.

8. Have you participated in, been enrolled in, or required to enter into any drug, alcohol, or other substance abuse recovery program?
   Yes No If "yes," attach a statement of explanation.

9. If you answered "Yes" to questions 5 through 8 above, have you received treatment or participated in any program that improves your ability to practice safely?
   Yes No N/A If "yes," attach a statement of explanation.

APPLICANT AFFIDAVIT

Provide a written explanation for all affirmative answers. Failure to do so ~~will~~ may result in this application being deemed incomplete. Falsification of the information on this application may constitute ground for denial or revocation of the license.

All items of information requested in this application are mandatory. Failure to provide any of the requested information may result in the application being deemed as incomplete and a deficiency notice being issued. An applicant who fails to complete all application requirements within 60 days after being notified by the board of deficiencies in his or her file may be deemed to have abandoned the application and may be required to file a new application, fee (as required by 16 CCR section 1749), and meet all the requirements in effect at the time of reapplication.

Collection and Use of Personal Information. The California State Board of Pharmacy of the Department of Consumer Affairs collects the personal information requested on this form pursuant to ~~as authorized by~~ Business and Professions Code Sections 30 and 4400 and following and California Code of Regulations title 16, division 17.~~4200 and 4202 and Title 16 California Code of Regulations Section 1793.5 and 1793.6.~~ The California State Board of Pharmacy uses this information principally to identify and evaluate applicants for licensure, issue and renew licenses, and enforce licensing standards set by law and regulation.

~~**Mandatory Submission.** Submission of the requested information is mandatory. The California State Board of Pharmacy cannot consider your application for licensure or renewal unless you provide all of the requested information.~~

Access to Personal Information. You may review the records maintained by the California State Board of Pharmacy that contain your personal information, as permitted by the Information Practices Act. The official responsible for maintaining records is the Executive Officer at the board's address listed on the application. Each individual has the right to review the files or records maintained by the board, unless confidential and exempt by law. ~~Civil Code Section 1798.40.~~

Possible Disclosure of Personal Information. We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed in the following circumstances:

- In response to a Public Records Act request (Government Code Section 6250 and following), as allowed by the Information Practices Act (Civil Code Section 1798 and following);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

***Address of Record:** Once you are licensed with the board, the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 and following ~~et seq.~~) and the Public Records Act (Government Code Section 6250 and following ~~et seq.~~) and will be ~~placed~~ available on the Internet. This is where the board will mail all correspondence. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your address of record is not your residence address,

you must also provide your residence address to the board, in which case your residence will not be available to the public.

****Disclosure of your U.S. social security ~~account~~ number or individual taxpayer identification number is mandatory**. Section 30 of the Business and Professions Code, Section 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security ~~account~~ number or individual taxpayer identification number. Your social security ~~account~~ number or individual taxpayer identification number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security ~~account~~ number or individual taxpayer identification number, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

NOTICE: The State Board of Equalization and the Franchise Tax Board may share taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if your state tax obligation is not paid.

MANDATORY REPORTER

Under California law, each person licensed by the California State Board of Pharmacy is a "mandated reporter" for both child and elder abuse or neglect laws.~~purposes.~~ California Penal Code Section 11166 and Welfare and Institutions Code Section 15630 require that all mandated reporters make a report to an agency specified in Penal Code Section 11165.9 and Welfare and Institutions Code Section 15630(b)(1) [generally law enforcement, state and/or county adult protective services agencies, etc.] whenever the mandated reporter, in ~~his or her~~ the licensees professional capacity or within the scope of ~~his or her~~ the licensees employment, has knowledge of or observes a child, elder and/or dependent adult whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or elder abuse or neglect. The mandated reporter must contact by telephone immediately or as soon as possible, to make a report to the appropriate agency(ies) or as soon as practicably possible. The mandated reporter must prepare and send a written report thereof within two working days or 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of ~~Section 11166 and Section 15630~~ the laws above is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both that imprisonment and fine. For further details about these requirements, ~~consult~~ refer to Penal Code Section 11164 and Welfare and Institutions Code Section 15630, and ~~subsequent~~ following sections.

APPLICANT AFFIDAVIT

~~(must be signed and dated by the applicant)~~ Must be signed and dated by the applicant. Must be received by the Board within 60 days

I, _____ , hereby attest to the fact that I am the
(Print full Legal Name)

applicant whose signature appears below. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this

application, including all supplementary statements. I understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____

Original Signature of Applicant Date

(please sign and date within 60 days of board receipt of the application)

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AFFIDAVIT OF COMPLETED COURSEWORK OR GRADUATION FOR PHARMACY TECHNICIAN

Instructions: The Director, Registrar, or Pharmacist must complete and sign this form certifying the identified individual has met the specified requirements in section 4202 of the Business and Professions Code and, if applicable, board regulations. ~~This form must be completed by the university, college, school, or pharmacist (The person who must complete this form will depend on how the applicant is qualifying).~~ All dates must include the month, day, and year ~~in order~~ for the form to be accepted.

This is to certify that _____ has
Print Full Name of Applicant

_____ Completed a pharmacy technician training program accredited by the American Society of Health-System Pharmacists (ASHP) as specified in Title 16, California Code of Regulations, Section 1793.6(a) on _____/_____/_____
(completion date must be included)

_____ Completed a training course that provided at least 240 hours of instruction as specified in Title 16, California Code of Regulations, Section 1793.6(c) on _____/_____/_____
(completion date must be included)

_____ Completed an Associate Degree in Pharmacy Technology and was conferred on ~~her/him on~~ _____/_____/_____
(graduation date must be included)

_____ Graduated from a school of pharmacy accredited or granted candidate status by the Accreditation Council for Pharmacy Education (ACPE). The degree of Bachelor of Science in Pharmacy or the degree of PharmD was conferred on _____/_____/_____
(graduation date must be included)

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of the above:
Signed _____ Title _____ Date_____

Name of Pharmacy Technician Training Program or School of Pharmacy _____
Address_____ Phone Number _____
Print Name of Director, Registrar, or Pharmacist _____
Email _____

Affix school seal here or Attach a business card of the pharmacist who provided the training pursuant to section 1793.6(c) of Title 16, California Code of Regulations here. The pharmacist's license number shall be listed.