NORTH DAKOTA STATE BOARD OF PHARMACY
1906 East Broadway Ave
BISMARCK ND 58501-4700
Phone (701) 328-9535
Fax (701) 328-9536
www.nodakpharmacy.com

MUST BE LEGIBLY PRINTED

APPLICATION FOR PROVISIONAL MILITARY SPOUSE PHARMACY TECHNICIAN REGISTRATION

Are you currently a spouse of an Active Member of the Military ◯ YES ◯ NO

If Yes, Please provide proof of being a spouse of an Active Member of the US Military

Have you been registered / licensed and worked in a Pharmacy as a Pharmacy Technician in another state for at least two of the last four-years? ◯ YES ◯ NO

If Yes, Please provide proof of the registration / licensure along with proof of being a nationally certified technician.

If you answered "NO" to any of these questions you are NOT eligible for this provisional registration / licensure

INSTRUCTIONS:

1. **Legibly print** and complete answers to all information requested.
2. Sign where indicated.
3. Submit a recent photo approximately 2 X 3 for identification.
4. Submit copies of official certificates of completion for a Pharmacy Technician Program and National Certification Certificate if completed.
5. Remit completed application, photo and other documents to Board of Pharmacy.

1.Name of Applicant in full _____

2.Home Address _____
Street & Number City State Zip

3. Date of Birth _____ Gender _____
Month Day Year

4. Place of Birth _____
City County State

5. Social Security Number_____-_____-_____ Phone#_____

6. Email Address: _____

7. Graduation from an American Society of Health Systems Pharmacists Accredited Pharmacy Technician Program:
(Enclose copy of Certificate if completed)

8. Certification by the Pharmacy Technician Certification Board [PTCB] or National Health Career Association [ExCPT]:
(*Enclose copy of Certificate if completed)*

9. Current Pharmacy of employment – if applicable_____
Name of Pharmacy

_____
Street Address City State Zip

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Registration No. _____ Original Date of Registration _____

DISCLOSURES

Have you ever voluntarily surrendered your registration or license issued by a federal or state controlled substance authority? ◯YES ◯NO

Has your license or registration ever been revoked, suspended, restricted, terminated or otherwise been subjected to disciplinary action [public or private] by any Board of Pharmacy or other state authority? ◯YES ◯NO

Are you presently under investigation or is there any disciplinary action pending against you by any licensing jurisdiction, the federal Food and Drug Administration, the federal Drug Enforcement Administration or any state drug enforcement authority for violation of any state or federal pharmacy, liquor or drug laws? ◯YES ◯NO

Have you ever been charged or convicted [including nolo contendere plea or guilty plea] of a felony or misdemeanor [other than minor traffic offenses] whether or not sentence was imposed, suspended, expunged, or whether you were pardoned from any such offense? ◯YES ◯NO

Do you currently have any condition or impairment including, but not limited to, substance or alcohol abuse or dependency, that in any way affects your ability to practice pharmacy in a safe and competent manner? ◯YES ◯NO

Have you ever had any application for initial registration or licensure, renewal of registration or licensure, or registration or licensure denied by any licensing authority whether in pharmacy or any other profession? ◯YES ◯NO

If you answered "YES" to any of the above Disclosure Questions, please include specific details for review and consideration.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the registration / license. I hereby certify under penalty of perjury under the laws of the State of North Dakota to the truth and accuracy of all statements and representations made in this application and that I personally completed the application. I understand that I must notify the Board in writing of any change of address or employment. I have read and understand the instructions and statements on this application.

Signed: _____

{Pharmacy Technician}

ANY CHANGES IN THE ABOVE INFORMATION <u>MUST</u> BE REPORTED TO THE BOARD OF PHARMACY OFFICE IMMEDIATELY.

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Registration No. _____ Original Date of Registration _____