

# PHARMACY INTERN REGISTRATION APPLICATION INSTRUCTIONS - RENEWAL

This application should be completed by Maryland registered Pharmacy Interns who are required to renew their registration in accordance with Maryland Health Occupation (HO) laws §12-6B-01 – 14 and COMAR 10.34.38.

- Complete the attached Maryland Board of Pharmacy's **Application for Pharmacy Intern Registration-Renewal**. This application is applicable to individuals renewing their pharmacy intern registration and who meets one of the following conditions:
  - Is currently enrolled in professional pharmacy education in a doctor of pharmacy program (program must be accredited by the Accreditation Council for Pharmacy Education or have precandidate or candidate status by the Accreditation Council for Pharmacy Education); or
  - Has graduated from a doctor of pharmacy program accredited by the Accreditation Council for Pharmacy Education.
- Applications must be submitted with one of the two affidavits (completed and signed) found in the back of this application packet.
- Applications must be postmarked **at least two weeks prior to expiration of your current registration** to ensure that you can continue practicing while the Board completes processing of the application and renders a decision. The Board may return incomplete applications, which may cause your current registration to expire before you are renewed.
- If an application is received **less than two weeks prior to expiration** of the current registration, or if additional information is needed due to an incomplete submission, the Board cannot guarantee that your new registration will be issued prior to the expiration of your current registration.
- If a renewal application has not been processed prior to the end of your birth month because of an incomplete or untimely submission, **you may not practice pharmacy in Maryland until the registration is renewed**.
- **Practicing without an active registration is a violation of the law and may result in disciplinary action by the Board of Pharmacy.**
- Submit the completed application with all required attachments and a check or money order made payable to the Maryland Board of Pharmacy in the amount of \$ 45.00 to:  
**Maryland Board of Pharmacy, P.O. Box 1991, Baltimore, Maryland 21203-1991.**
- Applications sent overnight or through priority mail must be addressed to the appropriate lockbox and sent to:  
**First Data /Remitco, Attn: Maryland Board of Pharmacy / LOCKBOX 7691  
400 White Clay Center Drive, Newark, DE 19711**

- A registrant's business address is **public information**. If the business address is not available, the registrant's home address may be released upon request under the Public Information Act, Maryland Code Annotated, General Provisions § 4-333(b)(2).
- If you are interested in volunteering for the Emergency Preparedness Task Force, please Visit: <http://dhmh.maryland.gov/pharmacy/Pages/emergency-preparedness-information.aspx> for more information and/or email [MDresponds.dhmh@maryland.gov](mailto:MDresponds.dhmh@maryland.gov) to register.

**NOTE:** The application fee is a non-refundable, administrative fee.

**Maryland Board of Pharmacy**  
 4201 Patterson Avenue  
 Baltimore MD 21215-2299  
 Phone: 410-764-4755  
 Fax: 410-358-6207  
 www.dhmh.maryland.gov/pharmacy



**APPLICATION FOR PHARMACY INTERN REGISTRATION - RENEWAL**

<b>RENEWAL APPLICATION</b>
<b>Total Due: \$45.00</b>

Please print clearly in ink or type in upper case letters only.

Complete all application sections and sign. **Incomplete forms will delay the issuance of your license.**

<b>VETERANS AND SPOUSAL PREFERENCE</b>	
Are you an active service member of the spouse or an active service member?	YES    NO
Are you a veteran or the spouse of a veteran who was discharged from active duty under a circumstance other than dishonorable within one (1) year of filing this application?	YES    NO

<b>1. IDENTIFICATION</b>				
<b>First Name:</b>				
<b>Middle / Maiden Name:</b>				
<b>Last Name:</b>				
<b>Application Date:</b>				
<b>Street Address:</b>				
<b>City:</b>		<b>State:</b>		<b>Zip:</b>
<b>Home Phone:</b>				
<b>Work Phone:</b>				
<b>Cell Phone:</b>				
<b>Social Security Number:</b>				
<b>Date of Birth:</b>				
<b>License #:</b>		<b>Expiration Date:</b>		
<b>Email Address:</b>				

2. EMPLOYMENT INFORMATION				
Employer Name:				
Date of Hire:				
Street Address:				
City:		State:		Zip:

3. CURRENT PHARMACY INTERN STATUS	
Check the category that best describes your current pharmacy intern status. Applicant must provide the additional documentation needed to validate this status.	
<input type="checkbox"/>	Currently enrolled in a doctor of pharmacy program (pharmacy school) <u>and</u> has completed 1 year of professional pharmacy education in a doctor of pharmacy program (program must be accredited by the Accreditation Council for Pharmacy Education or have precandidate or candidate status by the Accreditation Council for Pharmacy Education): <b>Must provide proof of enrollment utilizing Attachment 1: Pharmacy School Enrollment Affidavit.</b>
<input type="checkbox"/>	Has graduated from a doctor of pharmacy program accredited by the Accreditation Council for Pharmacy Education: <b>Must provide proof of graduation utilizing Attachment 2: Pharmacy School Graduation Affidavit.</b>

4. PHARMACY SCHOOL INFORMATION	
School Name:	
School Address (Including Country):	
School Phone Number:	
Graduation Date:	
Dates Attended:	
Degree Received:	BS Pharm.      Pharm D.
Is the School ACPE Accredited?	YES      NO

**5. REGISTRATION / LICENSURE HISTORY**

Have you applied for pharmacy registration or licensure in any other state?

**YES      NO**

*If YES, disclose all places, dates and results below. Attach additional sheets if necessary.*

Name of State	Date of Application	Registration/License Issued?
		<b>YES      NO</b>
Date Licensed	Registration/License Number	In Good Standing?
		<b>YES      NO</b>

Name of State	Date of Application	Registration/License Issued?
		<b>YES      NO</b>
Date Licensed	Registration/License Number	In Good Standing?
		<b>YES      NO</b>

## 6. PERSONAL ATTESTATION QUESTIONS

Please read this section carefully and answer the following questions related to your practice as a pharmacy intern. If you answer “yes” to any question, please provide a detailed explanation (attach additional pages if necessary) and supporting documentation. Failure to provide complete and correct information may result in delay, or denial, of your application for registration

1. Has any state licensing or disciplinary board (including Maryland) or any similar agency in the Armed Forces, denied your application for a registration, reinstatement or renewal, or taken any formal disciplinary action against any registration or license held by you? Such actions include, but are not limited to, reprimand, suspension, or revocation.	YES	NO
2. Has any state licensing or disciplinary board (including Maryland) or similar agency in the Armed Forces filed any complaints or charges against you or investigated you for any reason?	YES	NO
3. Have you surrendered or failed to renew a healthcare registration or license in any state?	YES	NO
4. Have you ever withdrawn your application for a pharmacy intern registration or other health professional license?	YES	NO
5. Has your employment by any pharmacy, clinic, healthcare practice, or wholesale drug distributor been terminated for disciplinary reasons?	YES	NO
6. Have you committed a criminal act for which you pled guilty or nolo contendere (see definition below), or for which you were convicted or received probation before judgment?	YES	NO
7. Excluding minor traffic violations are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?	YES	NO
8. Have you committed an offense involving alcohol or controlled substances to which you pled guilty or nolo contendere, or for which you were convicted or received probation before judgment?	YES	NO
9. Do you have a physical or mental condition that may impair your ability to practice as a pharmacy intern?	YES	NO
10. Has your ability to practice as a pharmacy intern been affected by the use of any type of drug or alcohol?	YES	NO

**\*\* Nolo contendere- A plea in a criminal case which has a similar legal effect as pleading guilty. The defendant does not admit or deny the charges, but a fine or sentence may be imposed based on this plea.**

I affirm that the information I have given in answer to these questions is true and correct to the best of my knowledge and belief. I have read the Maryland Pharmacy Act, Section 12-101 *et. seq.*, Health Occupations Article, Annotated Code of Maryland, and Board regulations, COMAR 10.34.01 *et seq.*, and if licensed, I agree to practice pharmacy in accordance with laws of Maryland.

<b>Signature:</b>	_____
<b>Date:</b>	_____

7. LIST OF DESIGNEES		
If applicable, list the names of person and/or entity that you authorize the Board to release information about your application:		
Name of Organization	Name of Person	Title

8. APPLICATION CHECKLIST		
Application Fee	YES	NO
Proof of Current Pharmacy School Enrollment—Attachment 1 (if applicable)	YES	NO
Proof of Graduation from a Doctor of Pharmacy Program—Attachment 2 (if applicable)	YES	NO
Birth Certificate or Other Proof of Birth Date	YES	NO

Would you like to be an emergency preparedness volunteer?	YES	NO
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I, \_\_\_\_\_, do solemnly swear or affirm under the penalties of perjury that I have personally completed this application, that the foregoing information is true, correct and complete to the best of my knowledge and belief, and that I understand that any misrepresentation will constitute grounds for revoking this registration.

<b>Applicant's Signature:</b>	_____
<b>Date:</b>	_____

**VOLUNTARY EQUAL OPPORTUNITY INFORMATION**

To further its commitment to equal opportunity, the Board of Pharmacy requests applicants to VOLUNTARILY provide the following information. This information will be used for statistical purposes only by authorized personnel.

<b>SEX:</b>	<b>MALE</b>	<b>FEMALE</b>
<b>RACE:</b>	<b>Are you of Hispanic or Latino origin?</b> (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)	<b>YES</b> <b>NO</b>

<i>If you are not of Hispanic or Latino origin, select one or more of the following racial categories:</i>	
<b>1. American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)</b>	
<b>2. Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the India subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)</b>	
<b>3. Black or African American (A person having origins in any of the black racial groups of Africa.)</b>	
<b>4. Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)</b>	
<b>5. White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)</b>	

**APPLICATION FOR PHARMACY INTERN RENEWAL  
ATTACHMENT 1  
PHARMACY SCHOOL ENROLLMENT AFFIDAVIT**

<b>Name of Applicant:</b>	
<b>School of Pharmacy:</b>	
<b>Address of School:</b>	
<b>Year in School (Select one):</b>	3      4
<b>Expected Date of Graduation:</b>	
<b>Social Security #:</b>	

**STATEMENT OF PHARMACY SCHOOL ENROLLMENT  
\*\* This section must be completed by the school/college of pharmacy \*\***

This is to certify that

\_\_\_\_\_

*NAME OF STUDENT*

is currently enrolled at \_\_\_\_\_ School/College of  
Pharmacy

<b>Initial Enrollment Date:</b>		
<b>Projected Graduation Date:</b>		
<b>School Address:</b>		
<b>School Phone:</b>		<b><u>SCHOOL SEAL</u></b>
<b>Dean or Designee Name:</b>		
<b>Title:</b>		

<b>Dean or Designee Signature:</b>	_____
<b>Date:</b>	
<b>Phone Number:</b>	

**APPLICATION FOR PHARMACY INTERN**

**ATTACHMENT 2**

**PHARMACY SCHOOL GRADUATION AFFIDAVIT**

The dean or registrar of your pharmacy school must complete this page unless you submitted an original Foreign Pharmacy Graduate Examination Committee (FPGEC) Certificate. The school seal **must** be placed on this page. **If this application is completed prior to graduation, the school must notify the Board after the applicant qualifies for graduation and has completed the experiential portion of his/her training.**

I certify that

\_\_\_\_\_

*NAME OF STUDENT*

Attended the \_\_\_\_\_  
School/College of Pharmacy

from \_\_\_\_\_ to \_\_\_\_\_

and earned \_\_\_\_\_ hours of actual pharmacy experience in a structured program conducted by or supervised by this School/College of Pharmacy, and on \_\_\_\_\_ graduated with the degree of \_\_\_\_\_.

Signed \_\_\_\_\_  
*Dean or Registrar*

Print Name:	
Print Title:	
Today's Date:	

PLACE THE SCHOOL SEAL OR STAMP ON THIS PAGE