

PHARMACIST LICENSE APPLICATION INSTRUCTIONS – RECIPROCITY

This application is to be completed by pharmacists licensed in states other than Maryland who would like to become Maryland licensed pharmacists in accordance with Maryland Health Occupation (HO) laws §12-305 and regulations (COMAR) §10.34.15.01.

- Complete the Maryland Board of Pharmacy's (Board) **Application for Pharmacist Licensure Reciprocity**, found online at www.dhmh.maryland.gov/pharmacy, and the **NABP Preliminary Application** found on the National Association of Boards of Pharmacy's ("NABP"), website at www.nabp.net.
- Submit the completed Board application with all attachments and a check or money order made payable to the Maryland Board of Pharmacy in the amount of **\$ 300.00** 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**
- Submit a copy of the NABP Preliminary Application to the Board. (Do Not submit any additional payment to the Board if you have already paid the \$300 Board application fee.)
- After receipt of your application, the Board will e-mail a Candidate Number to you. This number should be used whenever making inquiries to the Board about your application. **Please allow four to six weeks for processing of your application.**
- Register with NABP to take the Multistate Pharmacy Jurisprudence Examination (MPJE).
- After applying to NABP you will receive an "Authorization to Test" (ATT) number from NABP after all Board requirements are met. Upon receipt of the ATT number you may schedule an appointment to take the MPJE exam through Pearson VUE's website at www.pearsonvue.com/NABP.
- A score on the MPJE exam of 75 or better is considered passing. (ALL scores are only good for one year from the date of examination.)

Once you have passed all of your exams, you will receive an official Letter from the Board of Pharmacy that includes your new license number. You may use this letter as a temporary license until your printed license is received by mail. You may also verify your licensure status on the Board's web site at www.dhmh.maryland.gov/pharmacy

FOREIGN GRADUATES ONLY (in addition to the above):

- Must be Foreign Pharmacy Graduate Examination Committee (FPGEC) Certified with the National Association of Boards of Pharmacy (NABP) online at www.nabp.net and provide the Board with a copy of the FPGEC Certificate.
- 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 to register.

NOTE: Your application will be good for one year from the date received by the Board. If you wish to obtain a license and have not met all criteria within one year, you must resubmit an application and the applicable fees.

NOTE: Please allow seven to ten business days after receipt of the letter from the Board of Pharmacy that provides your license number to receive a printed license in the mail.

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.dhmv.maryland.gov/pharmacy



APPLICATION FOR PHARMACIST LICENSURE RECIPROCITY

Total Fee Paid: \$300.00	
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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.**

What date do you expect to begin working in Maryland? _____

VETERANS AND SPOUSAL PREFERENCE		
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

1. IDENTIFICATION			
First Name:			
Middle / Maiden Name:			
Last Name:			
Application Date:			
Street Address:			
City:		State:	
Home Phone:			
Work Phone:			
Cell Phone:			
Social Security Number:			
Date of Birth:		Place of Birth:	
Email Address:			

2. PHARMACY SCHOOL INFORMATION			
Pharmacy School Name:			
Foreign Graduate?	YES	NO	
Address of Pharmacy School:			
City:		State:	Zip:
Graduation Date:		Degree Received:	Pharm D BS Other: _____

3. TRAINING ON ADMINISTRATION OF SELF-ADMINISTERED DRUGS			
a. I attest that I have the proper training on the Administration of Self-Administered Drugs per COMAR 10.34.39	YES	NO	N/A
b. If "YES", do you have an active Certification in Basic Cardiopulmonary Resuscitation? If "YES", provide expiration date:	YES	NO	

4. LICENSURE HISTORY			
Indicate licensure information about all current and previously held licenses to practice pharmacy. Attach additional sheets if needed. <u>Submit a written explanation of any license that is not in good standing.</u>			
License Number & State	Original License Issue Date	License Expiration Date	Name, Address & Telephone Number of Last Employer

5. PERSONAL ATTESTATION QUESTIONS

Please read this section carefully and answer “YES” or “NO” to the following questions related to your practice as a pharmacist. If you answer “YES” to any question, please provide a detailed explanation (attach additional pages if necessary) and attach supporting documents to explain your answer. 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 license, 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 pharmacist’s license 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 (<i>see definition below</i>), 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 pharmacy?	YES	NO
10. Has your ability to practice pharmacy 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.

Signature:	_____
Date:	_____

Would you like to receive license renewal notification via email?	YES	NO
Would you like to be an emergency preparedness volunteer?	YES	NO

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 license

Applicant's Signature:	_____
Date:	_____

6. LIST OF DESIGNEE

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

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.

SEX:	MALE	FEMALE
RACE:	Are you of Hispanic or Latino origin?	YES NO

If you are not of Hispanic or Latino origin, select one or more of the following racial categories:

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.)	
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.)	
3.	Black or African American (A person having origins in any of the black racial groups of Africa.)	
4.	Native Hawaiian or other Pacific Islander (A person having origins in the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)	
5.	White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)	