PHARMACY TECHNICIAN REGISTRATION APPLICATION INSTRUCTIONS

This application should be completed by applicants who want to become Maryland Registered Pharmacy Technicians in accordance with Maryland Health Occupation (HO) laws §12-6B-01 – 14.

- Complete the attached Maryland Board of Pharmacy's **Application for Pharmacy Technician Registration**.
- Submit the completed application with all 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 2013, Baltimore, MD 21203-2013.

- Starter checks will not be accepted as payment.
- 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 7692
400 White Clay Center Drive, Newark, DE 19711

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

- Request a State of Maryland Criminal History Record Report from the Criminal Justice Information System ("CJIS") and provide the report to the Board.

NOTE: Your application will not be processed until the Board receives your completed CJIS report. To contact CJIS, please call 1.888.795.0011 and provide them with our CJIS authorization number #0600062013.

Please review the in-depth CJIS instructions located on the Board's website at http://www.dhmh.maryland.gov/pharmacy by clicking on the "Technician" tab and opening the Word document under general information.

- **Nationally Certified Applicants** must submit evidence of current certification by a national pharmacy technician certification program (legible true photocopy of the certificate).

- **Non-Nationally Certified Applicants** must submit evidence of completion of a Board-approved pharmacy technician training program that include 160 hours of work experience (including the signature of the registrar, pharmacy trainer, and/or pharmacy manager) and evidence of having passed a Board-approved technician examination (legible photocopy of documentation showing program completion and a passing score).

- **Reciprocity Applicants** must submit evidence of registration in another state under requirements similar to the registration requirements in Maryland (legible true photocopy of state registration) and a letter of good standing from the state Board in the state(s) of current registration. If your state does not require registration/licensure of pharmacy technicians with the board of pharmacy, you must submit a Pharmacy Work Experience Affidavit (Attachment 1) completed by the pharmacist under whom you worked as a pharmacy technician for at least six months preceding the pharmacy technician application date to the Maryland Board of Pharmacy.

- **All applicants** must be currently enrolled in high school, be a high school graduate, or have a GED.
- 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: Please allow four to six weeks for processing of your application.

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 TECHNICIAN REGISTRATION

Place a recent photograph in this space

Attach a photograph showing your face, with a three quarter view. The photograph **must be recent and in good condition.**

☐ **TOTAL FEE PAID: $45.00**

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.**

I certify that this is a photograph of me taken within the previous 180 days of submitting this application.	
Applicant's Signature:	

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

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

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

3. CERTIFICATION OR TRAINING INFORMATION			
Name of National Certification Program	Certification Number	Date of Certification	Expiration Date
Is your certification in good standing?		YES NO	
If no, please provide an explanation:			

OR

Name of Board Approved Training Program	Supervisor and Title	Date of Completion
Did you pass an examination approved by the Board?	YES NO	
Did you complete 160 hours of work experience as required by Maryland law?	YES NO	

Permit Holder or Designee Signature:	
Title:	
Date:	

4. EDUCATION INFORMATION					
Name of High School:					
Street Address:					
City:		State:		Zip Code:	
Have you graduated or received your GED?	YES NO	Date of Graduation/GED:			
Are you currently enrolled in high school?	YES NO				
If YES, please submit evidence that you are a student in good standing.					
Expected date of graduation:					

5. REGISTRATION / LICENSURE HISTORY *(For Reciprocity applicants: If your state does not require Pharmacy Technician Registration, please complete Attachment 1)*		
Have you applied for registration/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	Registration / License Issued?
		YES NO
Date Licensed	Registration/License Number	In Good Standing?
		YES NO
Name of State	Date	Registration / License Issued?

		◯ YES ◯ NO
Date Licensed	**Registration/License Number**	**In Good Standing?**
		◯ YES ◯ NO

6. PERSONAL ATTESTATION QUESTIONS

Please read this section carefully and answer the following questions related to your practice as a pharmacy technician. 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 technician 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 technician?	◯ YES ◯ NO
10. Has your ability to practice as a pharmacy technician 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 registered, I agree to practice pharmacy in accordance with laws of Maryland.

Signature:	
Date:	

7. STATE CRIMINAL HISTORY RECORDS CHECK	
I affirm that I submitted a request for a State Criminal History Records Check on:	YES NO
Applicant's Name:	
Applicant's Signature:	
Date:	

8. 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**

9. APPLICATION CHECKLIST	
Application Fee	YES NO
Recent Photograph	YES NO
Proof of National Certification (if applicable)	YES NO
Proof of Passing Board-Approved Examination (if applicable)	YES NO
Proof of State Registration and Good Standing (if applicable)	YES NO
Pharmacy Technician Work Experience Affidavit (if applicable)	YES NO
Birth Certificate or Other Proof of Birth Date	YES NO
CJIS Report or Proof of CJIS Report Request	YES NO

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 registration.	
Applicant's Signature:	
Date:	

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?** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)	◯ 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.)	☐

APPLICATION FOR PHARMACY TECHNICIAN RECIPROCITY CANDIDATES

ATTACHMENT 1:
PHARMACY TECHNICIAN WORK EXPERIENCE AFFIDAVIT

The pharmacy manager/supervisor/owner of the pharmacy where the pharmacy technician applicant worked as a pharmacy technician must complete this page. **The time period noted in this affidavit must include at least six months experience as a Pharmacy Technician.**

I certify that _____
Name of Pharmacy Technician

worked at the Pharmacy Practice Location _____

from _____ to _____

for a total of _____ hours in the role of a pharmacy technician.

Print Name:	
Print State Pharmacist License Number:	
Print Expiration Date:	
Print Title:	
Print Address of Pharmacy:	
Print Telephone Number of Pharmacy:	
Today's Date:	

I, _____, Supervising Pharmacist, 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.	
State of:	
County or City of	
Signature:	_____
	A.D., 20____

IMPORTANT NOTICE: This affidavit must be notarized and submitted with application where appropriate.