



California State Board of Pharmacy
 1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
 Phone (916) 574-7900
 Fax (916) 574-8618
 www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 GOVERNOR EDMUND G. BROWN, JR.

APPLICATION FOR A PHARMACY TECHNICIAN LICENSE

All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in an incomplete application and a deficiency letter being mailed to you. Please read all the instructions prior to completing this application. **Page 1, 2, and 3 of the application must be completed and signed by the applicant.** All questions on this application must be answered. If not applicable indicate N/A. Attach additional sheets of paper if necessary.

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)			
City	State	Zip Code	
Home#	Cell#	Work#	Email Address
Date of Birth (Month/Day/Year)	**Social Security No	Driver's License #	State

Mandatory Education (check one box)

Please indicate how you satisfy the mandatory education requirement in Business and Professions Code Section 4202(a).

High school graduate or foreign equivalent.

Attach a certified copy of your high school transcript, or certificate of proficiency, or foreign secondary school diploma along with a certified translation of the diploma.

Completed a General Education Development (GED)

Attach an official transcript of your GED test results.

TAPE A COLOR PASSPORT STYLE
 PHOTOGRAPH (2"X2") TAKEN
 WITHIN
 60 DAYS OF THE FILING OF THIS
 APPLICATION
NO POLAROID
OR
SCANNED IMAGES
 PHOTO MUST BE ON PHOTO
 QUALITY PAPER

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(1)(2)(3)(4) of the Business and Professions Code.

Attached 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 certificate - Date certified: _____

Attached is a certified copy of your military training DD214

Self-Query Report by the National Practitioner Data Bank Healthcare Integrity and Protection Data Bank (NPDB-HIPDB)

Attached is the sealed envelope containing my Self-Query Report from the NPDB-HIPDB. (This must be submitted with your application.)

FOR BOARD USE ONLY

Photo	<input type="checkbox"/>	FP Cards/Live Scan	<input type="checkbox"/>	License no	App fee no.
Enf 1 st Check	<input type="checkbox"/>	FP Cards Sent	<input type="checkbox"/>	Date issued	Amount
Enf 2 nd Check	<input type="checkbox"/>	FP Fees	<input type="checkbox"/>	Date expires	Date cashiered
Qualify Code		DOJ Clear Date:			
HIPDB	<input type="checkbox"/>	FBI Clear Date:			

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.

<p>1. <u>Do you have a medical condition which 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? If "yes," attach a statement of explanation. If "no," proceed to #2.</u> <u>Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program? _____</u> If "yes," attach a statement of explanation.</p> <p style="margin-left: 20px;"><u>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 medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for license.</u></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>																																
<p>2. <u>Do you currently engage, or have you been engaged in the past two years, in the illegal use of controlled substances?</u></p> <p style="margin-left: 20px;"><u>If "yes," are you currently participating in a supervised rehabilitation 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 <input type="checkbox"/> No <input type="checkbox"/></u></p> <p>Attach a statement of explanation.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>																																
<p>3. <u>Has disciplinary action ever been taken against your pharmacist license, intern permit or technician license in this state or any other state?</u> If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>																																
<p>4. <u>Have you ever had an application for a pharmacist license, intern permit or technician license denied in this state or any other state?</u> If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>																																
<p>5. <u>Have you ever had a pharmacy permit, or any professional or vocational license or registration, denied or disciplined by a government authority in this state or any other state? If "yes," provide the name of company, type of permit, type of action, year of action and state.</u></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>																																
<p>6. <u>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? If yes, provide company name, type of permit, permit number and state where licensed.</u></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>																																
<p>7. <u>Have you ever been convicted of any crime in any state, the USA and its territories, military court or foreign country?</u></p> <p style="margin-left: 20px;"><u>Check the box next to "YES" if, you have ever been convicted or plead guilty to any crime. "Conviction" includes a plea of no contest and any conviction that has been set aside or deferred pursuant to Sections 1000 or 1203.4 of the Penal Code, including infractions, misdemeanor, and felonies. You do not need to report a conviction for an infraction with a fine of less than \$300 unless the infraction involved alcohol or controlled substances. You must, however, disclose any convictions in which you entered a plea of no contest and any convictions that were subsequently set aside pursuant or deferred pursuant to sections 1000 or 1203.4 of the Penal Code.</u></p> <p style="margin-left: 20px;"><u>Check the box next to "NO" if you have not been convicted of a crime.</u></p> <p style="margin-left: 20px;"><u>You may wish to provide the following information in order to assist in the processing of your application: 1) certified copies of the arresting agency report; 2) certified copies of the court documents; 3) and a descriptive explanation of the circumstances surrounding the conviction (i.e. dates and location of incident and all circumstances surrounding the incident.) If documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required.</u></p> <p><u>Failure to disclose a disciplinary action or conviction may result in the license being denied or revoked for falsifying the application. Attach additional sheets if necessary.</u></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr style="background-color: #cccccc;"> <th style="width: 15%;">Arrest Date</th> <th style="width: 15%;">Conviction Date</th> <th style="width: 30%;">Violation(s)</th> <th style="width: 40%;">Court of Jurisdiction (Full Name and Address)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Arrest Date	Conviction Date	Violation(s)	Court of Jurisdiction (Full Name and Address)																													<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
Arrest Date	Conviction Date	Violation(s)	Court of Jurisdiction (Full Name and Address)																														

APPLICANT AFFIDAVIT

You must provide a written explanation for all affirmative answers. Failure to do so will result in this application being deemed incomplete. Falsification of the information on this application may constitute grounds 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 rejected as incomplete.

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 as authorized by Business and Professions Code Sections 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 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 by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

*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 et seq.) and the Public Records Act (Government Code Section 6250 et seq.) and will be placed 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 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. Your social security account 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, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

MANDATORY REPORTER

Under California law, each person licensed by the Board of Pharmacy is a "mandated reporter" for both child and elder abuse or neglect 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 professional capacity or within the scope of his or her 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 is 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 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 Penal Code Section 11164 and Welfare and Institutions Code Section 15630, and subsequent sections.

APPLICANT AFFIDAVIT

(must be signed and dated by the applicant)

I, _____, hereby attest to the fact that I am the applicant whose signature
(Print Full Legal Name)

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 also certify that I have read the instructions attached to this application.

Signature of Applicant

Date



California State Board of Pharmacy
 1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
 Phone (916) 574-7900
 Fax (916) 574-8618
 www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 ARNOLD SCHWARZENEGGER, GOVERNOR

**AFFIDAVIT OF COMPLETED COURSEWORK OR GRADUATION
 FOR PHARMACY TECHNICIAN**

Instructions: 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 Name of Applicant

Completed 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 by the American Council on Pharmaceutical Education (ACPE). The degree of Bachelor of Science in Pharmacy or the degree of PharmD was conferred on her/him 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: ____/____/____

Affix school seal here.

OR

Attach a business card of the pharmacist who provided the training pursuant to Section 1793.6(c) of the California Code of Regulation here.

University, College,
or School of
Pharmacy Name: _____

Address: _____

Print Name of
Director, Registrar,
or Pharmacist: _____

Phone
Number: _____

Email: _____