California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

To: **Board Members**

Subject: **Agenda Item X. Discussion of Proposed Changes to Application Questions for Individual Licenses and Possible Action to Initiate a Rulemaking to Amend California Code of Regulations, Title 16, Section 1793.5, Related to Pharmacy Technician Application**

Background

The federal Lorna Breen Health Care Provider Protection Act, Public Law No. 117-105 (Act) was enacted in March 2022 and aims to address mental health challenges faced by health care professionals. The Act includes several components with the goal of reducing stigma, enhancing support systems, and ultimately improving the wellbeing of health care workers.

In support of the Act, the Wellbeing First Champion Challenge program provides recommendations to licensing boards, hospitals, and health systems on wording for applications for health care professions so that the applications are free of intrusive mental health questions and stigmatizing language. It is recommended that the Board update application questions consistent with the recommendations. Three recommendations are offered for licensing boards to consider.

1. Ask one question that addresses all mental and physical health conditions as one, with no added explanations, asterisks, or fine print.
2. Refrain from asking probing questions about the applicant's health altogether.
3. Implement an Attestation Model that uses supportive language around mental health.

Staff note that the pharmacy technician application is incorporated by reference in regulation. As such, a formal rulemaking will be necessary to finalize changes to the pharmacy technician application.

Following implementation of revised applications, the Board can pursue the "Wellbeing First Champion Badge," which serves as a visual recognition for health care workers that licensing boards prioritize their mental health and wellbeing – removing a substantial barrier to mental health care access.

Related to this issue, the American Society of Health-System Pharmacists provides resources on its website.

Current Impairment or Limitation Question on the Individual Applications

Provided below is the current application language and questions related to this issue.

The Board makes an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the Board is unable to make a determination based on the information provided, the Board may require an applicant to be examined by one or more physicians or psychologists, at the Board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.

A. *Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice safely?*
   Yes ____ No____ ***If Yes, attach a statement of explanation.***

B. *Have you ever been diagnosed with a physical condition that may impair your ability to practice safely?*
   Yes ____ No____ ***If Yes, attach a statement of explanation.***

C. *Do you have any other condition that may in any way impair or limit your ability to practice safely?*
   Yes ____ No____ ***If Yes, attach a statement of explanation.***

D. *Have you ever participated in, been enrolled in, or required to enter into any drug, alcohol, or substance abuse recovery program or impaired practitioner program?*
   Yes ____ No____ ***If Yes, attach a statement of explanation.***

E. *If you answered "Yes" to questions listed under 8 (A through D) above, have you ever received treatment or participated in any program that improves your ability to practice safely?*
   Yes ____ No____ N/A____ ***If Yes, attach a statement of explanation.***

During the Licensing Committee's October 2024 meeting, members considered proposed changes to the application questions to align with the recommendations. Provided below is revised language approved by the Licensing Committee and Board.

The Board makes an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the Board is unable to make a determination based on the information provided, the Board may require an applicant to be examined by one or more physicians or psychologists, at the Board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.

1. *Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely*

affect your ability to practice pharmacy in a competent, ethical, and professional manner?

Yes ____ No____ ***If Yes, attach a statement of explanation.***

2. *Have you ever participated in, been enrolled in, or been required to enter into any drug, alcohol, or substance abuse recovery program or impaired practitioner program?*

   Yes ____ No____ ***If Yes, attach a statement of explanation.***

Since that time, staff submitted the draft intern pharmacist application for review and feedback from the Dr. Lorna Breen Heroes' Foundation (Foundation). Based on their review, it is recommended that the Board remove question two above. Their analysis included that the question:

> "is overly broad and invasive, and may discourage applicants from seeking treatment. Additionally, it is duplicative, as applicants are already asked about any current conditions that would impair or adversely affect their judgment or their ability to practice pharmacy in a competent, ethical, and professional manner.
>
> One of the primary reasons pharmacists, pharmacist interns, pharmacy technicians, and other healthcare professionals do not seek care is the fear that they will have to disclose it to a licensing board or future employer. If the applicant has been previously treated for a drug, alcohol or substance use disorder, or is currently receiving care, the care provider typically has obligations to report or intervene if there is a current threat to patient safety. In a past-treatment context, the existence of past treatment is not an indicator of future performance. And if there is ongoing treatment, it is likely that either the Board already is aware, or the treating professional has imposed limitations that would need to be disclosed under other required disclosures on the application. Requiring disclosure of treatment when there is no current impairment is one of the primary reasons why pharmacists, pharmacist interns, pharmacy technicians, and other healthcare professionals do not seek care. Fear and stigma are powerful, and including this question will deter treatment and arguably not benefit the institution."

<u>For Board Discussion and Consideration</u>
During the meeting, members will have the opportunity to review the recommendation offered by the Foundation. Following discussion by the Board, staff will begin updating forms as appropriate.

Further, as the pharmacy technician application is incorporated by reference in Section 1793.5, the Board will need to initiate a rulemaking to formally update the questions on the pharmacy technician application. In addition to updating the questions referenced, Board staff are recommending several nonsubstantive changes.

1. To provide clarity on requirements
2. To remove language from the application that is instructional only in favor of including such information in the application instructions
3. To update the affidavit for clarity.

Should members agree with the proposed changes, the following motion could be used to initiate the formal rulemaking process:

Possible Motion: Initiate a rulemaking to amend California Code of Regulations, Title 16, section 1793.5 ["as proposed" or "consistent with the Board's discussion]. Direct staff to submit the text to the Director of the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency for review, and authorize the executive officer to take all necessary steps to initiate the rulemaking process, make any nonsubstantive changes to the package, and set the matter for hearing, if requested. If no adverse comments are received during the 45-day comment period and no hearing is requested, authorize the executive officer to take all necessary steps to complete the rulemaking and adopt the proposed regulations at section 1793.5 as noticed.

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PHARMACY TECHNICIAN APPLICATION

~~Please r~~Read the application instructions prior to completing the ~~before you complete the~~ application. Failure to provide the requested information may result in the application being considered incomplete. ~~Attach additional sheets on paper if necessary.~~

TAPE A COLOR PASSPORT STYLE 2"X2" PHOTO TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION **NO POLAROID OR SCANNED IMAGES**

PHOTO MUST BE ON PHOTO QUALITY PAPER

_____ ~~**Military** (Are you currently serving in the United States military?)~~
_____ ~~**Veteran** (Have you ever served in the United States military?)~~

MILITARY EXPEDITE (~~Please c~~Check one ~~of the following~~, if applicable)

_____ **Military:** Currently serving in the United States military.
_____ **Veteran:** ~~(Have you s~~Served as an active duty member of the United States military and been honorably discharged~~?~~.~~)~~
_____**Active Duty Military Spouse or Domestic Partner:** ~~(Are you m~~Married to, or in a domestic partnership or other legal union with, an active duty member of the United States military who is assigned to a duty station in California under official active duty military orders and ~~do~~ you hold a current license in another state, district, or territory of the United States in the profession for which you seek licensure~~?~~.~~)~~

REFUGEE EXPEDITE (~~Please c~~Check one ~~of the following~~, if applicable)

_____ Refugee pursuant to section 1157 of title 8 of the United States Code.~~;~~
_____ Refugee granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to section 1158 of title 8 of the United States Code.~~; or,~~
_____ Refugee with a special immigrant visa that has been granted a status pursuant to section 1244 of Public Law 110-181, Public Law 109-163, or section 602(b) of title VI of division F of Public Law 111-8.

1. Applicant Information - ~~Please~~ Type or ~~P~~print in blue or black ink.

_____ _____ _____
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) Street City State Zip Code

_____ _____ _____
Home # Cell # Work #

_____ _____
Driver's License Number State Email Address

_____ _____
Date of Birth (Month/Day/Year) **US Social Security # or Individual Tax ID #

THIS SECTION IS FOR BOARD USE ONLY

App Fee: ___ Enf. Check: ___ Photo: ___ Qualify Code: ____ School Code: _____	FP Card/Fee: ___ LS: ___ DOJ Date__ FBI Date __ Self-Query ____	**Issuance**	**CASHIERING ONLY**	
		License #	*APPLICATION FEE*	
		Date Issued	Receipt #:	
		Date Expires	Date Cashiered:	
			Amount:	

APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS

REMINDER: The Self-Query Report from the National Practitioner Data Bank (NPDB) must be submitted with your application.

2. Mandatory Education

~~Please indicate~~ Check one to identify how you ~~satisfy~~ comply with the mandatory education requirement. ~~in Business and Professions Code section 4202(a).~~ [BPC §4202(a)] Include with the application the required supporting document as specified in the application instructions.

_____ United States ~~H~~high school graduate
~~Attach an official embossed transcript or notarized copy of your high school transcript, or certificate of proficiency.~~

_____ Graduate of f~~F~~oreign e~~E~~quivalent to United States h~~H~~igh s~~S~~chool
~~Attach a notarized copy of your foreign secondary school transcript or diploma along with a certified translation of the document if it is not in English.~~

_____ ~~Completed~~ Possess a general educational development certificate equivalent~~.~~
~~Attach an official transcript in a sealed envelope or notarized copy of your test results or certificate of proficiency.~~

3. Pharmacy Technician Qualifying Method ~~(check one box)~~

~~Please c~~Check one ~~of the boxes below indicating~~ to identify how you qualify ~~in order~~ to apply for a pharmacy technician license. ~~pursuant to section 4202(a)(1) through of the Business and Professions Code.~~ Include with the application the required supporting document as specified in the application instructions.

~~_____ Attached is the **Affidavit of Completed Coursework or Graduation** for: Associate degree in Pharmacy Technology, Training Course, or Graduate of a school of pharmacy.~~

_____ Obtained an associate's degree in pharmacy technology. [BPC §4202(a)(1)]

~~_____ Attached is a copy of PTCB or ExCPT certificate~~
_____ Completed a pharmacy technician training program accredited by the ASHP. [BPC §4202(a)(2) & 16 CCR §1793.6(a)]

~~_____ Attached is a copy of military training DD214~~
_____ Completed a pharmacy technician training program provided by a branch of the federal armed services. [BPC §4202(a)(2) & 16 CCR §1793.6(b)]

_____ Completed a course of training that satisfies the requirements of 16 CCR §1793.6(c). [BPC §4202(a)(2) & 16 CCR §1793.6(c)]

_____ Graduated from a school of pharmacy recognized by the Board. [BPC §4202(a)(3)]

_____ Certified by the Pharmacy Technician Certification Board or the National Healthcareer Association. [BPC §4202(a)(4) & 16 CCR §1793.65]

4. License Information

~~List all state(s) where you hold or held a license as a pharmacy technician, pharmacist, intern pharmacist, and/or another health care professional license, including California. Attach an additional sheet if necessary.~~

~~**State Registration Number Active or Inactive Issued Date Expiration Date**~~

~~_____ _____ _____ _____ _____~~

~~_____ _____ _____ _____ _____~~

Are you currently or have you previously been licensed as a pharmacist, intern pharmacist, pharmacy technician, any type of designated representative, and/or other healthcare professional?

Yes No If Yes, List the following for all state(s), including California. Attach additional sheets if necessary.

State	Type of License	License Number	Active or Inactive	Issued Date	Expiration Date

~~**Self-Query Report by the National Practitioner Data Bank (NPDB)**~~

~~_____ Attached is the original sealed envelope containing my Self-Query Report from NPDB. (This must be submitted with your application in a sealed envelope.)~~

~~**APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS.**~~

5. Ownership Information ~~- For any affirmative answer, attach a statement of explanation including company name, type of license, license number, and identify the state, territory, foreign country, or other jurisdiction where licensed.~~

~~1. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator, or medical director on a license to conduct a pharmacy, wholesaler, third-party logistics provider, or any other entity licensed in any state, territory, foreign country, or other jurisdiction?~~

~~Yes _____ No_____ If "yes," attach a statement of explanation.~~

Do you have or have you had any direct or indirect beneficial interest in, or do you have or have you previously exercised management and control over and/or served as an officer, director, manager and/or member of an LLC, partner, stockholder, trustee, professional director, or administrator for, a pharmacy, clinic, wholesaler, third-party logistics provider, or outsourcing facility licensed in California or any other state, jurisdiction, territory, or country?

Yes No If Yes, list all current and past licenses. Attach additional sheets if necessary.

Name of Facility	License Type and Number	State Issued

6. Disciplinary History -

The following questions pertain to a license sought or held in California or any other state, jurisdiction, territory, or ~~foreign~~ country~~, or other jurisdiction~~. ~~For any affirmative answer, attach a statement of explanation including type of license, license number, type of action, date of action, and identify the state, territory, foreign country, or other jurisdiction.~~

~~2. Have you ever had an application for pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration denied? Yes ____ No____ If "yes," attach a statement of explanation.~~

~~3. Have you ever had a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it? Yes ____ No____ If "yes," attach a statement of explanation.~~

~~4. Have you ever had a pharmacy, wholesaler, third-party logistics provider, and/or any other entity license denied, suspended, revoked, placed on probation, or had other disciplinary action taken? Yes ____ No____ If "yes," attach a statement of explanation.~~

A. Have you ever had an application and/or license for a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational or registration denied, suspended, revoked, placed on probation, or had other disciplinary action taken against it?
Yes **No** **If Yes,** provide a statement of explanation including the type of application and/or license type and number, type of action, date of action, and identify the state, jurisdiction, territory, or country.

B. Do you have or have you had any direct or indirect beneficial interest in, or have you exercised management and control over and/or served as an officer, director, manager and/or member of an LLC, partner, stockholder, trustee, professional director, or administrator for a California and/or nonresident pharmacy, clinic, wholesaler, third-party logistics provider, outsourcing facility and/or any other facility whose license has been denied, suspended, revoked, placed on probation, or had other disciplinary action taken against it?
Yes **No** **If Yes,** list all current and past licenses. Attach additional sheets if necessary.

Name of Facility	**License Type and Number**	**State Issued**

7. Practice Impairment or Limitation

~~The board will make an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the board is unable to make a determination based on the information provided, the board may require an applicant to be examined by one or more physicians or psychologists, at the board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.~~

~~5. Do you have an emotional, mental, or behavioral disorder that may impair your ability to practice safely? Yes ____ No____ If "yes," attach a statement of explanation.~~

~~6. Do you have a physical condition that may impair your ability to practice safely?~~

~~Yes _____ No_____ If "yes," attach a statement of explanation.~~

~~7. Do you have any other condition that may in any way impair or limit your ability to practice safely?~~
~~Yes _____ No_____ If "yes," attach a statement of explanation.~~

~~8. Have you participated in, been enrolled in, or required to enter into any drug, alcohol, or other substance abuse recovery program?~~
~~Yes _____ No_____ If "yes," attach a statement of explanation.~~

~~9. If you answered "Yes" to questions 5 through 8 above, have you received treatment or participated in any program that improves your ability to practice safely?~~
~~Yes _____ No_____ N/A_____ If "yes," attach a statement of explanation.~~

The ~~board~~ Board makes an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the Board is unable to make a determination based on the information provided, the Board may require an applicant to be examined by one or more physicians or psychologists, at the Board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.

A. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice pharmacy in a competent, ethical, and professional manner?
Yes **No** **If Yes,** provide statement of explanation.

8. APPLICANT ADVISEMENTS AND AFFIDAVIT
~~Provide a written explanation for all affirmative answers. Failure to do so may result in this application being deemed incomplete. Falsification of the information on this application may constitute ground for denial or revocation of the license.~~

All items of information requested in this application are mandatory. Provide a signed and dated written explanation for all affirmative answers. Failure to provide any of the requested information may result in the application being deemed ~~as~~ incomplete and a deficiency notice being issued. An applicant who fails to complete all application requirements within 60 days after being notified by the ~~b~~Board of deficiencies in ~~his or her~~ their file may be deemed to have abandoned the application and may be required to file a new application, fee ~~(as required by 16 CCR section 1749)~~, and meet all the requirements in effect at the time of reapplication. [16 CCR §1706.2]

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 pursuant to Business and Professions Code, ~~s~~Sections 30 and ~~c~~Chapter 9 of division 2, and California Code of Regulations, title 16, division 17. 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.

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 ~~b~~Board's address listed on the application. Each individual has the right to review the files or records maintained by the ~~b~~Board~~, unless confidential and exempt~~ to the extent permitted by law.

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 s~~S~~ections ~~6250 and following~~7920.000-7931.000), as allowed by the Information Practices Act (Civil Code s~~S~~ections 1798-1798.78 ~~and following~~);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

***Address of Record:** Once you are licensed with the ~~b~~Board, the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code sections 1798-1798.78~~ and following~~) and the Public Records Act (Government Code s~~S~~ections ~~6250~~ 7920.000-7931.000~~and following) and will be available on the Internet~~. This is where the ~~b~~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 ~~b~~Board, in which case your residence address will not be available to the public.

****Disclosure of your U.S. social security number or individual taxpayer identification number is mandatory**. Section 30 of the Business and Professions Code, s~~S~~ection 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security number or individual taxpayer identification number. Your social security number or individual taxpayer identification 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 number or individual taxpayer identification 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.

NOTICE: The State Board of Equalization and the Franchise Tax Board may share taxpayer information with the ~~b~~Board. You are obligated to pay your state tax obligation. This application may be denied, or your license may be suspended if your state tax obligation is not paid.

MANDATORY REPORTER

Under California law, each person licensed by the California State Board of Pharmacy is a "mandated reporter" for both child and elder abuse or neglect laws. California Penal Code ~~S~~section 11166 and Welfare and Institutions Code ~~S~~section 15630 require that all mandated reporters make a report to an agency specified in Penal Code ~~S~~section 11165.9 ~~and~~ or Welfare and Institutions Code ~~S~~section 15630(b)(1), as applicable, [generally law enforcement, state and/or county adult protective services agencies, etc.]

whenever the mandated reporter, in the licensee's professional capacity or within the scope of the licensee's 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~~ make an initial report ~~by telephone~~ immediately or as soon as practicably possible, ~~to make a report to the appropriate agency(ies) or as soon as practicably possible. The mandated reporter~~ and must ~~prepare and~~ send a written report ~~thereof~~ within a specified timeframe thereafter. ~~two working days or 36 hours of receiving the information concerning the incident.~~

Failure to comply with the requirements of the laws referenced above 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, refer to Penal Code ~~S~~section 11164 et seq. and Welfare and Institutions Code ~~S~~section 15630~~, and following sections~~ et seq.

APPLICANT AFFIDAVIT

Must be signed and dated by the applicant. Must be received by the Board within 60 days of signing.

I, _____ , hereby attest to the fact that I am the
(Print ~~f~~Full Legal Name)

applicant whose signature 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 understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____

Original Signature of Applicant Date

~~(please sign and date within 60 days of board receipt of the application)~~

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AFFIDAVIT OF COMPLETED COURSEWORK OR GRADUATION FOR PHARMACY TECHNICIAN

Instructions: The Director, Registrar, or Pharmacist must complete and sign this form certifying the identified individual has met the specified requirements in section 4202 of the Business and Professions Code and, if applicable, board regulations. All dates must include the month, day, and year for the form to be accepted.

This is to certify that _____ has
Print Full Name of Applicant

_____ Completed a pharmacy technician training program accredited by the American Society of Health-System Pharmacists (ASHP) as specified in Title 16, California Code of Regulations, Section 1793.6(a) on _____/_____/_____
(completion date must be included)

_____ Completed a training course that provided at least 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 _____/_____/_____
(graduation date must be included)

_____ Graduated from a school of pharmacy accredited or granted candidate status by the Accreditation Council for Pharmacy Education (ACPE). The degree of Bachelor of Science in Pharmacy or the degree of PharmD was conferred 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_____

Name of Pharmacy Technician Training Program, Course, or School of Pharmacy _____
Address_____ Phone Number _____
Print Name of Director, Registrar, or Pharmacist _____
Email _____ Pharmacy/Pharmacist License Number _____

Affix school seal here or Attach a business card of the pharmacist who provided the training pursuant to section 1793.6(c) of Title 16, California Code of Regulations here. The pharmacist's license number shall be listed.

AFFIDAVIT OF COMPLETED TRAINING COURSE OR PHARMACY TECHNICIAN TRAINING PROGRAM

Instructions: The Director, Registrar, or Pharmacist must complete and sign this form certifying the identified individual has met the specified requirements in Business and Professions Code section 4202 and, if applicable, Board regulations as listed in section 1 or 2 below. **All dates must include the month, day, and year for the form to be accepted.**

This is to certify that _____ has completed the following:
Print Full Name of Applicant

1. Business and Professions Code section 4202(a)(1) Pharmacy Technician Qualification:
   Obtained an associate's degree in pharmacy technology.
   Date of Completion: ____/____/____.

2. Business and Professions Code section 4202(a)(2) and Title 16, Division 17, Article 11, California Code of Regulations (CCR) section 1793.6 Pharmacy Technician Training Program: (Check one)

   CCR 1793.6(a): Completed a pharmacy technician training program accredited by the American Society of Health-System Pharmacists (ASHP).
   Date of Completion ____/____/____.

   CCR 1793.6(c)(1) and (2): Completed a training course that (1) provided a training period of at least 240 hours of instruction covering the knowledge and understanding as specified in 1793.6(c)(1)(A-G); and (2) satisfied the notification and other requirements set forth in 1793.6(c)(2)(A-D).
   Date of Completion: ____/____/____.

Name of Pharmacy Technician Training Course/Program: _____
Address _____ Phone Number _____
Print Name of Director, Registrar, or Pharmacist _____
Email _____ Pharmacy/Pharmacist License Number _____

I hereby certify 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.