**Memo from: Office of Health Professionals Regulation**
**Board of Pharmacy**

**To: All applicants for Pharmacist and Intern licenses**

**Date: December 10, 2012**

**Subject: Application fee increases**

**Addendum to the following license applications:**
Pharmacist by Examination
Pharmacist by Score Transfer
Pharmacist by Reinstatement
Intern Limited Pharmacist
Temporary 90-Day License to Practice Pharmacy by License Transfer

Please note that the fees listed in the attached application have been updated as of December 10, 2012. The correct fees are as follows:

| | |
|---|---|
| Pharmacist by Examination | $280 |
| Pharmacist by Score Transfer | $280 |
| Intern Limited Pharmacist | $70 |
| Temporary 90-Day License to Practice Pharmacy by License Transfer | $280 |

As of December 10, 2012, all applications for the above licenses must be accompanied by payment in full for the above amounts by check or money order.

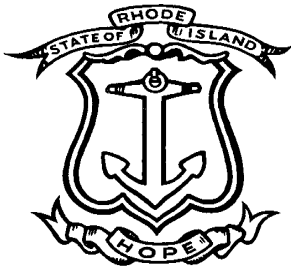
If you have any questions please contact the Board of Pharmacy at 401-222-2837.

*Rules and Regulations Pertaining to Pharmacists, Pharmacies and Manufacturers, Wholesalers and Distributors* (R5-19.1-PHAR) are available online at:

**http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/4606.pdf**

*** *Submit This Page With Application* ***

| ***FOR OFFICE USE ONLY*** |
| --- |
| AMT DUE $ _____ (current renewal fee) |
| Receipt # |
| ID# |
| Date Reinstated |




# State of Rhode Island
# Board of Pharmacy

Room 205
3 Capitol Hill
Providence, RI 02908-5097

## *Instructions and Application For*

# License To Practice Pharmacy By Reinstatement

***Please Check Type:*** ☐ **Less than 3 years** ☐ **3 years or more**

*Applicant - Print Name (First/MI/Last)*

**Phone: (401) 222-2837** **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

Revised 12/10/2012 jcp

# GENERAL INFORMATION

## Enclosures

The following materials and information are enclosed with this application packet.

General Information ..... 2
Application Process Overview ..... 2-4
Instructions for Completing the Board Application ..... 4-5
Board Application ..... 6-9
Application Checklist ..... 10
Interstate Verification Form ..... 11

## Reinstatement Requirements

- Payment of fee for current renewal period.
- Documentation of compliance with the continuing education requirements for the licensure period immediately prior to application (July 1-June 30), consisting of fifteen (15) hours, five (5) of which are "live" hours.
- License Verification(s) from the board(s) in which a license has been issued.
- Letter from employer indicating period of employment and duties of employment *(if expired 3 or more years)*.

### Web Sites

| | |
|---|---|
| Board of Pharmacy | www.healthri.org/hsr/professions/pharmacy.htm |
| License Verifications (All license types) | http://63.72.31.182/ (Use the above web site to print a verification of licensure prior to receipt of the official license.) |

***Rules and Regulations***

| | |
|---|---|
| Pharmacy Act | www.rules.state.ri.us/rules/released/pdf/DOH/DOH_2077.pdf |
| Disposal of Drugs | www.rules.state.ri.us/rules/released/pdf/DOH/DOH_165_.pdf |
| Distributors of Controlled Substances | www.rules.state.ri.us/rules/released/pdf/DOH/DOH_164_.pdf |
| Electronic Data Transfer | www.rules.state.ri.us/rules/released/pdf/DOH/DOH_162_.pdf |
| Hypodermic Needles/Instruments | www.rules.state.ri.us/rules/released/pdf/DOH/DOH_163_.pdf |

***Statutes***

| | |
|---|---|
| Pharmacy Act | www.rilin.state.ri.us/statutes/title5/5-19-1/index.htm |
| Collaborative Practice Act | www.rilin.state.ri.us/statutes/title5/5-19-2/index.htm |
| Controlled Substances Act | www.rilin.state.ri.us/statutes/title21/21-28/index.htm |
| Controlled Substances Therapeutic Research Act | www.rilin.state.ri.us/statutes/title21/21-28-4/index.htm |
| Drugs & Poisons Generally | www.rilin.state.ri.us/statutes/title21/21-30/index.htm |
| Food, Drugs & Cosmetics Act | www.rilin.state.ri.us/statutes/title21/21-31/index.htm |

***Federal Statutes/Forms/Manuals***

| | |
|---|---|
| Code of Federal Regulations | www.access.gpo.gov/nara/cfr/cfr-table-search.htm |
| DEA Registration Form (224, 224A) | www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html |
| DEA Applications and Reports On-line (Form 106, 41 ...) | www.deadiversion.usdoj.gov/21cfr_reports/index.html |
| Diversion Control Program Newsletters | www.deadiversion.usdoj.gov/pubs/nwslttr/index.html |
| Pharmacist's Manual | www.deadiversion.usdoj.gov/pubs/manuals/pharm2/index.htm |
| A Pharmacist's Guide to Prescription Fraud | www.deadiversion.usdoj.gov/pubs/brochures/pharmguide.htm |
| Poison Prevention Packaging: A Text for Pharmacists & Physicians | www.cpsc.gov/CPSCPUB/PUBS/384.pdf |

# APPLICATION PROCESS OVERVIEW

The Rhode Island Department of Health (HEALTH), Office of Health Professions Regulation, and the Rhode Island Board of Pharmacy (BOARD) conduct the reinstatement process in the State of Rhode Island. The BOARD utilizes the National Association of Boards of Pharmacy (NABP) for administration of examinations for licenses that have been expired, revoked or suspended for three or more years, and the licensee cannot provide documentation as to "practicing pharmacy" in another state.

## Application Process

In addition to the BOARD's application, you must submit additional information to the BOARD. All items listed on the checklist (page 11) must be submitted for an application to be considered complete. All applications are considered valid for six months from the day they are received at HEALTH. A new application and fee will be required if you do not complete the reinstatement process within those six months.

Please allow a minimum of 7 weeks for the reinstatement process to be completed. If you have had disciplinary history in Rhode Island or another state, it may take an additional two or three months for all pertinent documentation to be received, and a decision to be made by the BOARD regarding the reinstatement. Only applications that are complete will be declared eligible for the NAPLEX and MPJE examinations, in those cases where they are required.

Licenses will be issued within five working days following the BOARD's approval of the application for reinstatement. Wallet-sized licenses will be mailed approximately three weeks from the date of issuance, and are mailed to the address furnished in the application. It is the applicant's responsibility to notify the BOARD office, in writing, if the address changes during the interim. An address change may be emailed to the BOARD at the following web site.

**www.healthri.org/hsr/professions/pharmacy.htm**

HEALTH will not, for any reason, accelerate processing of one applicant at the expense of other applicants. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised you may be required to appear for an interview.

Note: You may not practice in Rhode Island until your license has been reinstated. The license will expire June 30th (regardless of the date it was reinstated), and a form will be mailed to renew the license for the period July 1st through June 30th.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the BOARD application. If you have any questions about this application process, or would like to check on the status of your BOARD application, contact the BOARD office at (401) 222-2837.

## Continuing Education

The BOARD requires completion of fifteen (15) hours, or 1.5 continuing education units, of continuing education courses sponsored by a recognized provider. Furthermore, five (5) hours, or 0.5 continuing education units of the required fifteen (15) hours of continuing education must be live hours.

A **"recognized provider"** is any person, group or organization approved by the BOARD as responsible or competent to provide continuing education courses and includes providers accredited by an appropriate national, regional or state accreditation agency. Any provider approved by the American Council on Pharmaceutical Education (ACPE), the board of pharmacy in another state or jurisdiction, or the provider of American Medical Association (AMA) Category I programs shall be considered recognized providers.

Any pharmacist whose license has not been renewed for one or more years, and is applying for reinstatement, must provide documentation of compliance with the continuing education regulations for the registration period immediately prior to application.

# APPLICATION PROCESS OVERVIEW

(continued)

**Examinations Requirement**

R5-19-PHAR, Section 7.3.1, requires that:

***"Any pharmacist license or registration that has lapsed, been revoked or suspended and the pharmacist has not practiced pharmacy, as defined by the Board, for three (3) years requires that he/she take and pass the same examinations required for initial licensure or registration.***

Section 1.40 defines **"practice of pharmacy"** as:

***" … the interpretation, evaluation and dispensing of prescription drug orders; participation in drug and device selection; drug regimen reviews, provision of patient counseling and the provision of those acts or services necessary to provide pharmaceutical care; and the responsibility for compounding and/or labeling of drugs and devices (except labeling by a manufacturer, repackager, or distributor of non-prescription drugs and commercially packaged legend drugs and devices)."***

***If the applicant has not been "practicing pharmacy" in another state*,** then the pharmacist would have to successfully pass the North American Pharmacy Licensure Examination (NAPLEX) and the Multistate Pharmacy Jurisprudence Examination (MPJE). The continuing education requirement shall not be required when the examinations are required.

The NAPLEX and MPJE are computer-adaptive examinations administered through the National Association of Boards of Pharmacy (NABP). The BOARD utilizes this agency for a licensee whose registration have been lapsed, revoked, or suspended for three or more years, and the pharmacist has not practiced pharmacy in another state during that period. A book of Rhode Island laws will be mailed upon receipt of the application for reinstatement.

If the applicant falls into this category, a NAPLEX/MPJE Registration Bulletin (BULLETIN) is enclosed with this application. The BULLETIN is not included for reinstatements that are less than three years. Contrary to the instructions in the BULLETIN, ***do not*** mail the NAPLEX/MPJE registration forms and fees to the BOARD. They are to be mailed directly to the NABP at the following address.

**NABP Licensure Exam**
**700 Busse Highway**
**Park Ridge IL 60068**

The NABP will electronically report the NAPLEX and MPJE scores to the BOARD. The BOARD will notify the applicant of the scores attained at the completion of the application process.
***If the applicant has been "practicing pharmacy" in another state***, then the following documentation would be required as part of the application process.

- ☐ Letter from employer indicating period of employment, and duties performed.
- ☐ License Verification(s) from the board(s) in which a license has been issued.

The letter from the employer must be atached to the BOARD application when it is submitted to the BOARD. In ***all*** cases of reinstatement, the licensee must send a license verification form to each board in which a license has been issued. This form is to be mailed directly to the Rhode Island Board of Pharmacy by the licensing authority.

You may obtain the telephone numbers of all U.S. licensing authorities at the National Association of Boards of Pharmacy web site.

**www.nabp.net/whoweare/boards.asp**

Please, ***do not*** contact the Rhode Island Board for information on other licensing authorities.

# INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Carefully read the following instructions and those throughout the application packet before completing the BOARD application. ***Only complete applications with the appropriate fee will be accepted***. Failure to submit all required information and appropriate documentation might result in processing delays. All of the information provided is subject to change.

## General Instructions

1. Make a copy of the application and forms before you begin in case a mistake is made.
2. Type information, or print in blue or black ballpoint pen. BOARD staff will not make assumptions about illegible information.
3. Provide a response to each section or question. Otherwise, mark **"N/A"** for "Not Applicable".
4. Make a copy of the completed application before submitting it to the BOARD.
5. It is the applicant's responsibility to check on the status of the application.

## Completing the Application

1. Complete the Board Application (pages 7-10). You must respond to ***all*** components of the application as instructed. If separate pages are attached in continuation of the Board application, such pages MUST clearly indicate the section for which the information is being reported.
2. The application must be notarized.
3. Forward a License Verification Form (page 12) to each licensing authority in which a pharmacist license has been issued. This form may be duplicated as needed.
4. If applicable, attach a letter from your employer, indicating the period of employment, and the duties that are being performed.

Make a check or money order (in U.S. funds only) for the fee written on the front of the application, payable to **RI General Treasurer**, and staple it to the upper left-hand corner of the cover page of the application. This reinstatement fee of the BOARD is NONREFUNDABLE.

Complete all application materials as instructed and arrange them in the order as they appear in the application checklist (page 11). Attach all documents to the BOARD application, and mail to the BOARD at the following address.

**Rhode Island Department of Health**
**Board of Pharmacy**
**Room 205, 3 Capitol Hill**
**Providence, RI 02908-5097**

***Except for the Verification Form, and instruction pages, do not detach any pages from this booklet.*** The application must be submitted to the BOARD with its cover page.

***Contact the Post Office as to the packet's proper postage.***

**Completing the NABP Registration Forms** *(if applicable)*

Registration is made directly with the NABP for the North American Pharmacist Licensure Examination (NAPLEX), and the Multistate Pharmacy Jurisprudence Examination, with each examination having a specified fee. The NAPLEX/MPJE Registration Bulletin (BULLETIN) will answer questions pertaining to the following.

- Registration Forms and Fees
- Refunds and Withdrawals
- Requesting Special Testing Accomodations
- Completing the Registration Forms
- Testing Administration
- Authorization to Test
- Scheduling Examination Appointments
- Scheduling Special Testing Accomodations
- Changing Examination Appointment
- Testing Centers
- NAPLEX/MPJE Administration
- Score Results
- Re-Examination

Contrary to the instructions in the BULLETIN, ***do not*** mail the NAPLEX/MPJE registration forms and fees to the BOARD. They are to be mailed directly to the NABP at the following address.

**NABP Licensure Exam**
**700 Busse Highway**
**Park Ridge, IL 60068**

After receipt of your registration forms, the NABP will contact the BOARD to confirm your eligibility to sit for the NAPLEX and MPJE. The BOARD will confirm eligibility for the examination, ***only*** if all required documentation has been received.

Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

# State of Rhode Island
# Board of Pharmacy

## Application for License to Practice Pharmacy By Reinstatement

*Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.*

### 1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

### 2. Social Security Number

– –

U.S. Social Security Number

**"Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN) will be transmitted to the Divison of Taxation to verify that no taxes are owed to the State."**

### 3. Gender

☐ Male ☐ Female

### 4. Date of Birth

Month Day Year 1 9

### 5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code –

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone – Home Fax –

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

### 6. Business Address

It is your responsibility to notify the board of all address changes.

***This address will appear on the Department of Health web site.***

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code –

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone – Extension Business Fax –

## 7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

## 8. Qualifying Education

Please list the name and information about the accredited college of pharmacy from which you graduated.

Type of School (University, College, Trade/Technical School etc.)

Name of School

Date Enrolled: Month Day Year

Date Graduated: Month Day Year

Degree Received (Bachelor of Arts, Doctor of Pharmacy)

Major

Specialty/Type

Credit Hours

**College documentation does not have to be submitted.**

## 9. Pharmacist Licensure

List all states or country that you are now licensed as a pharmacist, or have applied for licensure.

☐ Check here if not applicable.

State/Country: _____ ☐ Active ☐ Inactive ☐ Pending

State/Country: _____ ☐ Active ☐ Inactive ☐ Pending

_____ ☐ Active ☐ Inactive ☐ Pending

_____ ☐ Active ☐ Inactive ☐ Pending

_____ ☐ Active ☐ Inactive ☐ Pending

_____ ☐ Active ☐ Inactive ☐ Pending

**DOCUMENTATION:** Send Interstate Verification Form to each entity. *(See page 12)*

## 10. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation of, or plead Nolo Contendere to any federal, state or local statute, regulation or ordinance, or entered into a plea bargain related to a felony (including convictions for driving under the influence)? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance): Month Year

For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

## 11. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer **"Yes"** to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

Attach a typed explanation on a separate 81/2 x 11 sheet of paper.

1. Have you ever had any disciplinary action(s) taken, or is any pending, against your License to Practice, or are any complaints pending in the State of Rhode Island or any other state? ☐ Yes ☐ No
2. Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation? ☐ Yes ☐ No
3. Are there any charges or investigations pending, in any state, against you? ☐ Yes ☐ No
4. Have you ever failed to pass an examination for licensure as a pharmacist? ☐ Yes ☐ No

**Note:** If you answered "**yes**" to any of these questions, you must attach a typed explanation on a separate sheet of paper.

## 12. Activities

In chronological order, list what you have been doing during the year(s) your license has been expired, revoked, or suspended.

Include all activities, including those that are not directly related to pharmacy.

| Month | Year | | Month | Year | |
|---|---|---|---|---|---|
| | | — | | | |
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| | | — | | | |

**DOCUMENTATION:** Explain all gaps on a separate 8½ x 11 sheet of paper.

## 13. Affidavit of Applicant

Complete this section and sign in the presence of a notary public. Make sure that you and the notary public have completed all components accurately and completely.

Application will be returned if not notarized.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentality's (local, state, federal or foreign) to release to the Rhode Island Board of Pharmacy any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice pharmacy in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Pharmacy of any change in the answers to these questions after this application and this affidavit is signed.

_____ Signature of Applicant

_____ Date of Signature (MM/DD/YY)

**The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did/did not take an oath.**

_____ Name of Notary (Print, Type or Stamp)

_____ Signature of Notary

Notary Seal

_____ Notary No/Commission No.

_____ Commission Expiration Date (MM/DD/YY)

*** ***Detach Page - Do Not Submit With Application*** ***

# APPLICATION CHECKLIST

Review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

## Board Application

- ☐ I have read and understand the "Application Instructions", for completing the application.
- ☐ I have completed the Rhode Island Board application as instructed on page 5.
- ☐ I have completed Section 13, **"Affidavit of Applicant"**, and had the form notarized by a notary public.
- ☐ I have a check or money order (preferred), made payable (in U.S. funds only) to the ***"RI General Treasurer"*** in the total amount specified on the application, and have attached it to the upper left-hand corner of the application's cover page.
- ☐ I have arranged my reinstatement materials in the following order.

  1. Fee (attached as instructed).
  2. Board application (cover page and pages 7-10).
  3. Documentation of continuing education compliance.
  4. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.]
  5. Letter from employer, indicating period of employment, and duties performed *(applicants whose license has been lapsed, revoked or suspended for three or more years.)*

- ☐ I have mailed the above materials directly to the Board of Pharmacy, Department of Health.

## Other Documents

- ☐ I am/was licensed in another state, and have mailed a Verification of License form to each board in which I was licensed as a pharmacist.

## Examination Registrations *(if applicable)*

- ☐ I have submitted the registration forms and fees for the NAPLEX and MPJE directly to the National Association of Boards of Pharmacy.

*Substitute forms are not acceptable - This form may be duplicated as needed .*

**Rhode Island Board of Pharmacy**
*Room 205, Three Capitol Hill*
*Providence, RI 02908-5097*
*(401) 222-2837*

# INTERSTATE VERIFICATION FORM - OTHER STATES OF LICENSURE

## THIS SECTION TO BE COMPLETED BY APPLICANT

I am applying for reinstatement of my license to practice as a registered pharmacist in the State of Rhode Island. The Rhode Island Board of Pharmacy requires that the following form be completed by the jurisdiction in which I obtained a license. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Pharmacy at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____

## THIS SECTION TO BE COMPLETED BY PHARMACY BOARD

| License Status: ☐ Active ☐ Inactive ☐ Lapsed | Original Date Issued: | Expiration Date: |
|---|---|---|
| | Reinstatement Date: (if applicable) | |

Reason for "Inactive Status"

Questions:

1. Has this licensed pharmacist ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensed pharmacist incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Consent Order, final action, etc..).

_____

_____

_____

## Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____

Please Affix Board Seal Here

*Please return directly to the Board at the above address. Thank you for your prompt cooperation.*