

Arkansas Application for Pharmacist Licensure by Examination

Completion of this application form is necessary for consideration for a license by examination as a pharmacist pursuant to Arkansas Pharmacy Law and Regulation. Disclosure of this information is voluntary. However, failure to disclose all requested information may result in this form not being processed and may subsequently result in denial of this application. All candidates for licensure, renewal, and/or examination have an obligation to update and supplement the information and responses on this application if they change. Failure to supplement the information and responses provided on this application may result in denial or other appropriate action. All information provided must be accurate. Please note that the information provided on this application is subject to the public information laws of this jurisdiction.

Carefully follow the directions on this application form. In addition, note the following:

1. Type or print legibly with black or blue ink only.
2. **The registration and application fees are NOT refundable.**
3. Disclosure of your U.S. social security number, if you have one, is mandatory. The Arkansas State Board of Pharmacy is required under 42 USC § 666(a)(13) and Ark. Code Ann § 17-1-104 to obtain the social security numbers of all licensees to provide to the Arkansas Office of Child Support to assist in the identification of persons who are delinquent in complying with a child support order, spousal support/alimony order or in the repayment of educational loans.
4. If the name shown on your supporting documentation is different from that shown on your application, you must submit proof of legal name change – a certified copy of your marriage license, divorce decree, affidavit or court order.

Supporting Documentation and Fees:

Submit the following documents and fees:

- A passport style photo should be attached to page 1 of the application.
- A copy of your driver's license with this application. If you do not have a driver's license, you may substitute another form of picture identification. Please contact us if you have questions about the picture ID.
- A copy of your birth certificate.
- The [Criminal Background Check Identity Verification Form](#), if you have not already completed one. Applicants who have completed a criminal background check for the Arkansas State Board of Pharmacy within the last four years are exempt from this requirement.
 - A check in the amount of \$35 made payable to the Arkansas State Board of Pharmacy for your statewide and federal criminal background check. This may be combined with the \$25 fee for a total of \$60.
 - A completed **fingerprint card**. You **MUST use a standard FBI fingerprint card, form No. FD-258 used by the FBI for noncriminal fingerprinting**. You can contact the State Board of Pharmacy office to have one sent to you. Email your mailing address to asbp@arkansas.gov or call (501) 682-0190 to request a card.
- A check or money order made payable to the *Arkansas State Board of Pharmacy* for either \$25 (no background check needed) or \$60 (background check needed) for your application for licensure by examination which qualifies you to take the NAPLEX.
- Supplemental information as specified in the application.

Your application is NOT considered complete until all supporting documents and fees have been received by the Arkansas State Board of Pharmacy.

NOTE: An applicant who has a criminal conviction may seek to have the conviction waived and the application approved, subject to appropriate terms and conditions. The request for waiver shall be on a form provided by the Board and shall be accompanied by all documentation specified in Parts IV, V and VI that have not already been delivered to the Board. The request for waiver shall not be considered until the application, all fees, all the documentation, both federal and state criminal background check reports, and a request for wavier form stating the applicant's reasons why the conviction should be waived are received by the Executive Director.



Arkansas State Board of Pharmacy
322 South Main Street, Suite 600
Little Rock, AR 72201
 501-682-0190 ♦ Fax 501-682-0195
 www.pharmacyboard.arkansas.gov

TAPE A PHOTOGRAPH
 TAKEN WITHIN 60 DAYS
 OF THE FILING OF THIS
 APPLICATION
 IN THIS SPACE

2016

ARKANSAS APPLICATION FOR PHARMACIST LICENSURE BY EXAMINATION APPLICATION FEE: \$25.00 or \$60 with background check fees (if needed)

PART I: APPLICANT IDENTIFYING INFORMATION

Social Security Number: _____ **Gender:** Male Female

Race: White Black/African American Asian American Indian/Alaska Native Other: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Last First Middle Suffix (Jr.)

Name: _____

Identify any maiden name, surname, or any other names or aliases you have been known by or used and identify the reason for your name change.

Other Names Used: _____

Date of Birth: _____ **Place of Birth(city, state, county and country):** _____

Street City State Zip

Current Home Address: _____

If different from current address listed above.

Permanent Mailing Address: _____

Home Phone Number: () **Cell Phone Number:** ()

Work Phone Number: () **Work Fax Number:** ()

Email: _____

Will you practice pharmacy while physically present in the State of Arkansas? YES NO

Have you submitted a criminal background check to the Arkansas State Board of Pharmacy within the last 4 years? YES NO
 If YES, when?

If NO, complete and submit a Criminal Background Check Identity Verification Form and fingerprint card.

Citizenship:

a. Are you a Citizen of the United States? YES NO

- b. If you answered NO to the question above, are you: (Please check one of the following.)
- a qualified alien (as defined in 8 U.S.C. § 1641.)
 - a nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 et seq.)
 - an alien who is paroled into the United States under 8 U.S.C. § 1182 (d)(5) for less than one year.
 - other – please provide a detailed explanation.

FOR OFFICE USE ONLY

Fee Submitted: _____ Check No.: _____

PART II: PREVIOUS EXAMINATION RECORD

Have you previously taken the NAPLEX or any other board-administered examination for licensure? YES NO

If **YES**, you must disclose places, dates, and results in the following spaces:

Name of State	Date of Exam (MM/YYYY)	Outcome (Passed or Failed)

PART III: EDUCATION INFORMATION

Pre-Pharmacy College Training (Prior to Entering Pharmacy College)

Name & Location of College Attended	Period of Attendance (MM/YYYY)		Degree, if any
	From	To	

Pharmacy College Training (Completed)

Name & Location of College of Pharmacy Attended	Period of Attendance (MM/YYYY)		Degree, if any
	From	To	

PART IV: RECORD OF LICENSURE INFORMATION

If you have ever been licensed, certified or registered to practice pharmacy (as a technician, intern or pharmacist), or held any other professional license, certification or registration, complete the information below – if you need additional space, use a separate sheet of paper to complete this section.

State	Title of License, Certification or Registration	License, Certificate or Registration Number	Date of Issue	In Good Standing? Answer yes or no.*

*If license is not current and in good standing, please explain on a separate sheet.

PART V: PERSONAL HISTORY INFORMATION

You must respond fully and truthfully to these questions and, if the answer is “Yes” to any part of these questions, you **must** provide a notarized written detailed explanation of the circumstances.

You must fully and truthfully report your criminal history whether or not the arrest/citation was dismissed, dismissed through drug court diversion, expunged under the first offender act, alternative sentencing act, Act 531, Act 305, or Act 346 or it happened over 5 years ago. This criminal history includes all DWI, DUI, and MIP (Minor in Possession) violations, possession of controlled substances, theft, shoplifting, domestic violence, assault violations, or any other violation of any state or federal law, whether misdemeanor or felony, and regardless of the state or territory in which it happened.

If you do not fully and truthfully report your history, your application will be denied and/or you will be subject to other sanctions. Please contact the Arkansas State Board of Pharmacy at 501-682-0190 if you do not understand the above information.

Have you had any application for any professional license or registration refused or denied by any licensing authority?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever voluntarily surrendered a professional license or registration?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever been the subject of a disciplinary action with regard to any license or registration?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever had a license or registration revoked, suspended or subjected to other disciplinary action?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
To your knowledge, have any unresolved or pending complaints ever been filed against you with any professional licensing agency or association?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Is there any disciplinary action pending against you by any licensing jurisdiction, the USDA, Drug Enforcement Agency, or any state drug enforcement authority?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever been cited, arrested for, charged with, or convicted of (including a <i>nolo contendere</i> plea or guilty plea) a criminal offense in any state or in federal court (other than minor traffic violations) whether or not sentence was imposed or suspended?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever been pardoned from a criminal conviction?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever had a record expunged?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you ever been cited, arrested for, charged with, or convicted of (including a <i>nolo contendere</i> plea or guilty plea) a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you now or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you currently have an alcohol or other substance abuse problem?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Within the last five (5) years have you had a license or certification revoked or suspended, other disciplinary action taken, or an application for licensure or certification refused, revoked or suspended by any professional licensing authority of another state, territory or country?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

PART VI: CERTIFICATION OF DEGREE CONFERRAL

This page of your application is to be completed by the Registrar or Dean at your college or school of pharmacy.

COLLEGE AFFIDAVIT	
This is to certify that	_____
	<i>Full Legal Name of Applicant</i>
attended the	_____
	<i>College or School of Pharmacy</i>
from	_____ to _____
with a degree conferral date of	_____
	<i>Month/Day/Year</i>
	with the degree of Pharm.D.
Signature:	_____
Printed Name of Dean or Registrar:	_____
Check one: Dean <input type="checkbox"/> Registrar <input type="checkbox"/>	

FOR NOTARY USE ONLY:

State of: _____	County of: _____
Sworn to before me this _____ day of _____, 20 _____	
_____ Notary Public Signature	
My Commission Expires: _____	
Print, Type, or Stamp Name of Notary	

PART VII: CERTIFICATIONS

Please read carefully and sign below.

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge, and that the copy of my driver's license or other identifying photographic identification attached hereto is a true likeness of myself. I authorize the Arkansas State Board of Pharmacy to review state files pertaining to my registration and practice, and all law enforcement records, administrative records, motor vehicle records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of eligibility for the NAPLEX. I hereby certify under penalty of perjury under the laws of the State of Arkansas to the truth and accuracy of all statements and representations made in this application and that I personally completed the application. I have read and understand the instructions and statements on this application.

Signature of applicant (Full Legal Name) Date signed

For Notary Use:

State of _____

County of _____

Sworn before me this _____ day of _____, _____
day *month* *year*

My commission expires _____

NOTARY SEAL

Signature Notary Public