

PENNSYLVANIA STATE BOARD OF PHARMACY
PO BOX 2649
HARRISBURG, PA 17105-2649

Telephone: (717) 783-7156
Fax: (717) 787-7769
Website: www.dos.pa.gov/pharm

Courier Address: 2601 N. Third Street
Harrisburg, PA 17110
E-Mail: st-pharmacy@pa.gov

APPLICATION FOR REGISTRATION AS A PHARMACY INTERN (Rev. 4/15)

INSTRUCTIONS: Please fully complete Section A. Section B should be completed if applicable to your situation. Arrange for completion of either Section C or Section D (whichever page applies to your particular situation), then please submit Sections A, B, and either C or D of the application along with the required application fee to the Board of Pharmacy office. Insert your name, address, and social security number at the top of Section E (page 4) and forward Section E (page 4) to your school of pharmacy for completion. The dean or registrar must complete the remaining items under Section E (page 4) and then the dean or registrar must directly mail Section E (page 4) of the application to the Board of Pharmacy office.

Additional Application Requirement as of January 1, 2015

The Bureau of Professional and Occupational Affairs (BPOA), in conjunction with the Department of Human Services (DHS), is providing notice to all health-related licensees and funeral directors that are considered "mandatory reporters" under section 6311 of the Child Protective Services Law (CPSL) (23 P.S. § 6311), as amended, that EFFECTIVE JANUARY 1, 2015, all persons applying for issuance of an initial license shall be required to complete 3 hours of DHS-approved training in child abuse recognition and reporting requirements as a condition of licensure. Please review the Board website for further information on approved CE providers. Once you have completed a course, the approved provider will electronically submit your name, date of attendance, etc., to the Board. [Child Abuse Continuing Education Providers Information can be found here.](#)

Please review and maintain for future reference the following important information.

1. At least 1,500 hours of approved internship, with a maximum allowable credit of 50 hours in any one week, must be earned in order to sit for the licensure examinations. Please keep in mind that, if you have **more** than one registered pharmacist preceptor and intern hours are being reported under these preceptors for the same time period, you will be asked to provide payroll records, pay stubs or other documentation to confirm that your preceptors are not reporting more than 50 intern hours in any given week during overlapping time periods.
2. Please maintain a copy of all documents submitted to the Board or received from the Board for future reference.
3. If you are a graduate of a foreign pharmacy school, please do not have your school of pharmacy's dean or registrar complete Section E unless:
 - a. You graduated after June 2002 with a Pharm.D. degree from the Lebanese American University in Byblos, Lebanon **OR**
 - b. You graduated from a baccalaureate program accredited by the Canadian Council for Accreditation of Pharmacy Programs (CCAPP) commencing in 1993 and continuing until June 30, 2004.

4. A pharmacist preceptor:
 - a. Must have an unrestricted Pennsylvania pharmacist license.
 - b. Must be engaged in the active practice of pharmacy in the Commonwealth of Pennsylvania.
 - c. Must be working on a full-time basis in the pharmacy where the intern will train.
 - d. May not have been convicted of a criminal offense relating to the practice of pharmacy.
 - e. May not direct the training of more than two pharmacy interns at any one time, unless the program has been approved by the Board for a greater number of interns.
 - f. Must notify the Board, in writing, when his/her supervision ends for an intern.
5. The intern must inform the preceptor of the date that the Board granted approval of registration as a pharmacy intern or the approval date to add a pharmacist preceptor. Internship hours can be earned only on or after that approval date.
6. A preceptor application must be filed each time the intern changes or adds a pharmacist preceptor in order for the intern to receive credit for the hours that were earned under that preceptor. The “Application to Change or Add a Pharmacist Preceptor” may be downloaded at www.dos.pa.gov/pharm.
7. NOTICE: Disclosing your Social Security Number on this application is mandatory in order for the State Boards to comply with the requirements of the Federal Social Security Act pertaining to Child Support Enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa.C.S. § 4304.1(a). At the request of the Department of Human Services (DHS), the licensing boards must provide to DHS information prescribed by DHS about the licensee, including the social security number. In addition, Social Security Numbers are required in order for the Board to comply with the reporting requirements of the U.S. Department of Health and Human Services, National Practitioner Data Bank.
8. Licenses and registrations are not forwarded. Provide a valid mailing address on your application.

If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance. It is the responsibility of the applicant to provide all required documentation to the Board within the required time frame.

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APPLICATION FOR REGISTRATION AS A PHARMACY INTERN #854-101 (Rev. 4/15)

Application fee - \$35.00 check or money order payable to the "Commonwealth of Pennsylvania." The fee is not refundable nor transferable. Note: A processing fee of \$20 will be charged for any check or money order returned unpaid by your bank regardless of the reason for nonpayment.

SECTION A – TO BE COMPLETED BY INTERN

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET

_____ CITY STATE ZIP CODE

PHONE NUMBER: _____ SOCIAL SECURITY NO. _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____

VERIFICATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

Applicant's written signature *Date*

SECTION B – TO BE COMPLETED BY MOST GRADUATES OF FOREIGN PHARMACY SCHOOLS

Note: An applicant from a foreign pharmacy program must have FPGEC certification. Please arrange for the National Association of Boards of Pharmacy (NABP) to **directly** send to the Pennsylvania State Board of Pharmacy an "Official Copy" of your FPGEC certificate. Please see Sections 3(a) and 3(b) of the directions for the exceptions to this requirement. If you are required to have FPGEC certification, do not complete Section E.

FPGEC Certificate Number: EE # _____ FPGEC Certification Date: _____

Name of Pharmacy College/School: _____

Location of College/School (City & Country): _____

Graduation Date: _____ Degree Awarded: _____

PLEASE REVIEW SECTION C AND SECTION D TO DETERMINE WHICH OF THESE SECTIONS IS APPLICABLE TO YOUR SITUATION. ONLY ONE OF THESE SECTIONS - EITHER C OR D - SHOULD BE SUBMITTED, NOT BOTH. NOTE: MOST APPLICANTS WILL NEED TO SUBMIT SECTION D.

SECTION C - FOR USE BY STUDENTS WHO ATTEND PHARMACY SCHOOLS LOCATED OUTSIDE OF PENNSYLVANIA AND WHO ARE COMPLETING ONLY SCHOOL-RELATED ROTATIONS IN PENNSYLVANIA

Section C should be completed only if:

1. The student attends a pharmacy school located outside of Pennsylvania AND
2. The student will complete only school-related internship programs in Pennsylvania.

Please have the **Experiential Director** of your school of pharmacy's controlled internship program provide the following information:

Pharmacy intern's name: _____

Date of birth: _____ Last four numbers of social security number: XXX-XX-_____

Pharmacy name (internship site): _____

Pharmacy address: _____, PA _____
STREET CITY ZIP CODE

Pharmacy permit number: _____

Are you a director of controlled internships at a pharmacy school located outside of Pennsylvania?

Yes _____ No _____

Name of pharmacy school: _____

Pharmacy school address _____

VERIFICATION

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Experiential Director's Written Signature *Date*

If Section C (page 2) is applicable to your situation, do not complete Section D (page 3).

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**SECTION D – TO BE COMPLETED BY PRECEPTOR IF SECTION C DOES NOT APPLY.
MOST APPLICANTS WILL NEED TO SUBMIT SECTION D.**

Pharmacy intern's name: _____

Date of birth: _____ Last four numbers of social security number: XXX-XX-_____

Pharmacist preceptor's name: _____

Pharmacist preceptor's license number: _____

Pharmacy name (internship site): _____

Pharmacy address: _____, PA _____
STREET CITY ZIP CODE

Pharmacy permit number: _____

Are you a director of controlled internships at a Pennsylvania pharmacy school? Yes _____ No _____

Are you currently registered with the Pennsylvania State Board of Pharmacy as a preceptor for another intern? (Not applicable for college sponsored internship programs) Yes _____ No _____

If yes, give pharmacy intern's name _____

And the pharmacy intern's certificate number PI- _____

STATEMENT

I have never been convicted of any criminal offense with respect to the observance of federal, state and municipal laws and ordinances relating to the practice of pharmacy, and I have not committed any act that would justify revocation or suspension of my license pursuant to the Pharmacy Act, Section 5.

I am familiar with the practice act and the regulations of the State Board of Pharmacy and I agree to conduct my responsibilities as a pharmacist preceptor in accordance with these laws and regulations.

I am aware that the regulations require that I notify the State Board of Pharmacy each and every time I train a new pharmacy intern and that I am required to file preceptor registration for each pharmacy intern.

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

SIGNATURE OF PRECEPTOR

DATE

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SECTION E – ENROLLMENT IN OR GRADUATION FROM A SCHOOL OF PHARMACY ACCREDITED BY THE ACCREDITATION COUNCIL FOR PHARMACY EDUCATION (ACPE)

The student should enter his/her name, address and social security number below and forward this page to the school of pharmacy's dean or registrar for completion. **The dean or registrar must complete the remainder of Section E (page 4) and then directly submit Section E (page 4) to the Board of Pharmacy.**

*Graduates of foreign pharmacy schools who have obtained FPGEC certification are exempt from submitting Section E.

Pharmacy student's name: _____

Pharmacy student's address: _____
STREET ADDRESS

_____ CITY STATE ZIP CODE

Pharmacy student's social security number: _____

The above-named student has successfully completed at least two (2) years of college and is enrolled or accepted as a student of pharmacy in, or has graduated from, the ACPE-accredited pharmacy degree program (Pharm.D. or B.S. in Pharmacy) at the college/school listed below.

NAME OF COLLEGE/SCHOOL

SCHOOL SEAL

SIGNATURE OF DEAN OR REGISTRAR DATE

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