

STATE BOARD OF PHARMACY  
 PO Box 2649  
 Harrisburg, PA 17105-2649  
 Web site: [www.dos.pa.gov/pharm](http://www.dos.pa.gov/pharm)  
 E-Mail Address: [st-pharmacy@pa.gov](mailto:st-pharmacy@pa.gov)

**Application for Reactivation of a Pharmacist License that has been  
 Expired or Inactive for Less Than 4 Years**

\*\*This application cannot be used for the purpose of renewing a current license.\*\*

<p><b>To assist with the COVID-19 response, the fee and continuing education requirement for this application will be waived.</b></p> <p><b>This application is valid only during the COVID-19 Emergency Declaration.</b></p>	<p>Name _____  <small>(First) (Middle) (Last)</small></p> <p>Maiden Name _____  <small>(if applicable)</small></p> <p>Current Address:</p> <p>Street _____</p> <p>City _____</p> <p>State _____ Zip Code _____</p> <p>Telephone No. _____ Date of Birth _____  <small>(Include the area code) (Month/ Day/ Year)</small></p> <p>E-Mail Address _____</p> <p>U.S. Social Security No. _____</p> <p>PA Pharmacist License No. _RP- _____</p>
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	YES	NO
1. Are you submitting a name change with this reactivation?		
<p><b>Change name to:</b> _____</p> <p>You must submit a copy of a legal document verifying the name(s). The following are acceptable name change verification documents:</p> <ul style="list-style-type: none"> <li>Marriage Certificate</li> <li>Divorce decree which indicates the retaking of your maiden name</li> <li>Other "legal" document indicating the retaking of a maiden name</li> <li>For a "legal" name change, a copy of the court document must be provided</li> </ul>		

Print your NAME: \_\_\_\_\_ PA Pharmacist License No. \_\_\_\_\_

	YES	NO
2. With the exception of the one you are currently reactivating, do you hold, or have you ever held a license, certificate, permit, registration or other authorization to practice any health-related profession or occupation in any state or jurisdiction?		
Please provide the profession/occupation and state or jurisdiction here:		
<b>If you answer yes to questions 3, 4 and/or 5, provide copies of all disciplinary actions from the boards that imposed actions and a personal detailed statement. If you answer yes to questions 6, 7 and/or 8, provide copies of pertinent documents and a personal detailed statement.</b>		
3. Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?		
4. Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
5. Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?		
6. Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?		
7. Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?		
8. Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?		

Print your NAME: \_\_\_\_\_ PA Pharmacist License No. \_\_\_\_\_

**ACKNOWLEDGEMENT OF DUTY TO SELF-REPORT DISCIPLINARY CONDUCT AND CERTAIN CRIMINAL ACTIVITY**

I, \_\_\_\_\_, hereby acknowledge that in addition to any existing reporting requirement required by a specific board or commission, I am **REQUIRED** pursuant to Act 6 of 2018 to **NOTIFY the Bureau of Professional and Occupational Affairs WITHIN 30 DAYS of the occurrence of any of the following:** (1) A disciplinary action taken against me by a licensing board or agency in another jurisdiction; (2) A finding or verdict of guilt, an admission of guilt, a plea of nolo contendere, probation without verdict, a disposition in lieu of trial or an Accelerated Rehabilitative Disposition (ARD) of any felony or misdemeanor offense in a criminal proceeding. **I further acknowledge that failure to comply with these mandatory reporting requirements may subject me to disciplinary action by the Board.** I acknowledge my understanding that to self-report a disciplinary action or criminal matter as set forth above, I may log in to the Pennsylvania Licensing System (PALS) at [www.pals.pa.gov](http://www.pals.pa.gov) and select "Mandatory Reporting by Licensee" under the heading "Your Licenses."

\_\_\_\_\_  
Licensee Signature

\_\_\_\_\_  
Date (month/day/year format)

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.

\_\_\_\_\_  
Licensee Signature

\_\_\_\_\_  
Date (month/day/year format)

This application and any attachments should be e-mailed to: [st-pharmacy@pa.gov](mailto:st-pharmacy@pa.gov)

Questions should be directed to: [st-pharmacy@pa.gov](mailto:st-pharmacy@pa.gov)

Verify the license status at [www.pals.pa.gov/verify](http://www.pals.pa.gov/verify)

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