

STATE OF MAINE

BOARD OF PHARMACY

**APPLICATION FOR
PHARMACIST LICENSURE**



Department of Professional and Financial Regulation

Office of Licensing and Registration
35 State House Station
Augusta, ME 04333-0035

Office Telephone: (207) 624-8689 or (207) 624-8620
TTY/HEARING IMPAIRED (207) 624-8563
FAX: (207) 624-8637

Office located at: 122 Northern Avenue, Gardiner, Maine
Email: susan.a.greenlaw@state.me.us

APPLICATION INSTRUCTIONS LICENSURE BY SCORE TRANSFER

THE FOLLOWING IS INCLUDED IN THIS PACKET

(Please contact this office if any of these items are missing):

- Application for licensure by Score Transfer
- NAPLEX/MPJE Registration Bulletin - www.nabp.net
- Instructions on preparing for the Multi-state Pharmacy Jurisprudence Exam
- SBI Criminal Background Check Form. Please provide a payment of a separate \$8.00 fee for a criminal records (SBI) check. Make check payable to: Treasurer, State of Maine
- Credit card authorization form
- Accommodation request form (Americans with Disabilities Act)

THE FOLLOWING IS THE APPLICATION PROCEDURE:

- Complete the application for licensure by score transfer (check the appropriate box) as directed on the application and submit to the Maine Board along with the required fee. The fee for Maine Licensure is \$150 (payment may be made in the form of a check or money order payable to Treasurer, State of Maine, VISA or MasterCard – see credit card authorization form).
- Complete the Multi-state Pharmacy Jurisprudence Examination registration form (included in the Registration Bulletin) and submit with your application for licensure. The fee for the MPJE is \$85 (payment must be made in the form of a certified bank check or money order and made payable to NABP). NABP will NOT accept a personal check.
- Once the completed applications are received at the Board office, a letter of acknowledgment will be sent to you.
- Score Transfer reports and MPJE results will be reported electronically to the Maine Board. The applicant will then be notified of a passing or failing score. If the applicant passes, a license will be issued without delay. If the applicant fails, please contact the Board Clerk for information on retaking the exam.

Questions or concerns should be directed to Susan Greenlaw, Board Clerk at (207) 624-8689.

IF YOU HAVE A DISABILITY AND MAY REQUIRE SOME ACCOMMODATION IN TAKING THIS EXAMINATION, BE SURE TO FILL OUT AND SUBMIT THE ENCLOSED "REQUEST FOR ACCOMMODATION" FORM ALONG WITH THIS APPLICATION. IF ACCOMMODATION IS NOT REQUESTED IN ADVANCE, WE CANNOT GUARANTEE THE AVAILABILITY OF ACCOMMODATION ON-SITE.

APPLICATION INSTRUCTIONS LICENSURE BY EXAMINATION (NAPLEX)

THE FOLLOWING IS INCLUDED IN THIS PACKET
(Please contact this office if any of these items are missing):

- Application for licensure by examination
- NAPLEX/MPJE Registration Bulletin - www.nabp.net
- Instructions on preparing for the Multi-state Pharmacy Jurisprudence Exam
- SBI Criminal Background Check Form. Please provide a payment of a separate \$8.00 fee for a criminal records (SBI) check. Make check payable to: Treasurer, State of Maine
- Accommodation request form (Americans with Disabilities Act)

THE FOLLOWING IS THE APPLICATION PROCEDURE:

- Complete the application for licensure by examination (check the appropriate box) as directed on the application.
- Complete the NAPLEX registration form (included in the Registration Bulletin) The fee for the NAPLEX is \$250 (payment MUST be in the form of a certified bank check or money order payable to NABP). NABP will NOT accept a personal check.
- Complete the MPJE registration form (included in the Registration Bulletin). The fee for the MPJE is \$85 (payment must be made in the form of a certified bank check or money order payable to NABP). NABP will NOT accept a personal check.

NOTE: Please be sure to read the NAPLEX/MPJE Registration Bulletin carefully. It contains very important information about these exams. All of the above items may be submitted at the same time. The payments, however, must be made separately.

- Upon receipt, the applications will be reviewed to determine your eligibility. Once your completed applications have been accepted, *this office will submit the appropriate registration forms directly to NABP*. You will then be notified, in writing, that your applications have been accepted and forwarded to NABP.
- NAPLEX and MPJE results are reported electronically to the Maine Board. The applicant will then be notified, in writing, of a passing or failing score.

IF YOU HAVE A DISABILITY AND MAY REQUIRE SOME ACCOMMODATION IN TAKING THIS EXAMINATION, BE SURE TO FILL OUT AND SUBMIT THE ENCLOSED "REQUEST FOR ACCOMMODATION" FORM ALONG WITH THIS APPLICATION. IF ACCOMMODATION IS NOT REQUESTED IN ADVANCE, WE CANNOT GUARANTEE THE AVAILABILITY OF ACCOMMODATION ON-SITE.



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 DEPARTMENT OF PROFESSIONAL
 AND FINANCIAL REGULATION
 MAINE BOARD OF PHARMACY
 35 STATE HOUSE STATION

AUGUSTA, MAINE

04333-0035

Direct Tel: (207) 624-8689 Receptionist: (207) 624-8603
 FAX: (207) 624-8637 - TTY/Hearing Impaired: (207) 624-8563

ANGUS S. KING, JR.
 GOVERNOR

ANNE L. HEAD
 DIRECTOR

Internet Address: susan.a.greenlaw@state.me.us

✓ **CHECK ONE:**

- Licensure by Examination (includes application review, and license upon successfully passing the NAPLEX™ and MPJE)
- Licensure by Score Transfer (includes application review, and license upon successfully passing the NAPLEX and MPJE) \$150.00 **Payable to Treasurer, State of Maine.**

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRSA section 175 as authorized by the Tax Reform Act of 1976 (42 USC section 405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA section 191.

Please attach a current photograph to this application.

COMPLETE THE FOLLOWING IN INK (TYPE OR PRINT):

Name:		
Mailing Address:		
City:	State:	Zip Code:
County:	Telephone #: (____) _____ - _____	
Social Security #: (____)-(____)-(____)		Date of Birth: _____

Employment (drug stores only):

Dates: From _____ To _____

From _____ To _____

From _____ To _____

College of Pharmacy: _____

Date of graduation: _____

Date of high school graduation: _____

Number of times examined by the Board: _____

Date(s): _____

Have you ever been convicted of a crime other than a minor traffic violation? Yes No

If yes, please describe below in detail the crime(s), list date(s), and submit a copy of the court judgement(s) as well as a letter from you explaining the circumstances surrounding your conviction.

I include herewith sworn and certified statements in support of my application and one sworn certificate of good moral character.

I, _____, being duly sworn, do say
(Printed name)

upon oath, that the statements made by me in this application for licensure as a pharmacist by examination are true and correct.

Applicant's signature in full _____

State of _____

Date _____

County of _____

The foregoing instrument was acknowledged before me this _____
(date)

by _____
(name of person acknowledged)

Signature of Notary Public _____

Name of Notary Public (Printed) _____

Notary Public, State of _____

My commission expires: _____

CERTIFICATE OF GRADUATION IN PHARMACY EDUCATION

To be completed and signed by the Secretary or Dean of the school or college of pharmacy of which the applicant is a graduate.

This is to certify that _____
(name of applicant)

is a graduate of the _____,
(name of college)

the degree of _____

having been conferred on _____ on the _____ day of

_____, 19_____, and that _____ had previously attended

regular courses of instruction as follows:

From the ____ day of _____ 19____, to the ____ of _____ 19____

From the ____ day of _____ 19____, to the ____ of _____ 19____

From the ____ day of _____ 19____, to the ____ of _____ 19____

From the ____ day of _____ 19____, to the ____ of _____ 19____

From the ____ day of _____ 19____, to the ____ of _____ 19____

From the ____ day of _____ 19____, to the ____ of _____ 19____

From the ____ day of _____ 19____, to the ____ of _____ 19____

From the ____ day of _____ 19____, to the ____ of _____ 19____

A total of _____ weeks.

Date: _____

Signature: _____
Secretary or Dean of

Location _____

SEAL

AFFIDAVIT OF EXPERIENCE

State of _____, County of _____,

I, _____, a licensed pharmacist, holder of
license number _____, issued by the _____ Board of
Pharmacy, a resident of _____ in the county of
(city/town)

_____ and state of _____,

do hereby certify that I am personally acquainted with _____,
the applicant, and that for the period of _____, from the _____
day of _____, 19_____, to the _____ day of
_____, 19_____, said _____

was under my direction and instruction in the compounding and selling of drugs, in the
retail drug store or pharmacy of _____,
located at _____.

Enter total number of hours worked: _____

State of _____ Date _____

County of _____

The foregoing instrument was acknowledged before me this _____
(date)

by _____
(name of person acknowledged)

Signature of Notary Public _____

Name of Notary Public (Printed) _____

Notary Public, State of _____

My commission expires _____

AFFIDAVIT OF EXPERIENCE

State of _____, County of _____,

I, _____, a licensed pharmacist, holder of
license number _____, issued by the _____ Board of
Pharmacy, a resident of _____ in the county of
(city/town)

_____ and state of _____,

do hereby certify that I am personally acquainted with _____,
the applicant, and that for the period of _____, from the _____
day of _____, 19_____, to the _____ day of
_____, 19_____, said _____

was under my direction and instruction in the compounding and selling of drugs, in the
retail drug store or pharmacy of _____,
located at _____.

Enter total number of hours worked: _____

State of _____ Date _____

County of _____

The foregoing instrument was acknowledged before me this _____
(date)

by _____
(name of person acknowledged)

Signature of Notary Public _____

Name of Notary Public (Printed) _____

Notary Public, State of _____

My commission expires _____

My commission expires: _____

AFFIDAVIT OF EXPERIENCE

State of _____, County of _____,

I, _____, a licensed pharmacist, holder of
license number _____, issued by the _____ Board of
Pharmacy, a resident of _____ in the county of
(city/town)

_____ and state of _____,

do hereby certify that I am personally acquainted with _____,
the applicant, and that for the period of _____, from the _____
day of _____, 19_____, to the _____ day of
_____, 19_____, said _____

was under my direction and instruction in the compounding and selling of drugs, in the
retail drug store or pharmacy of _____,
located at _____.

Enter total number of hours worked: _____

State of _____ Date _____

County of _____

The foregoing instrument was acknowledged before me this _____
(date)

by _____
(name of person acknowledged)

Signature of Notary Public _____

Name of Notary Public (Printed) _____

Notary Public, State of _____

My commission expires _____

My commission expires: _____



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Board of Pharmacy
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 GOVERNOR

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 DIRECTOR



AUTHORIZATION OF CREDIT CARD PAYMENT

Fees owed to this Department may be paid by the use of a credit card. If you wish to pay your fee(s) with your credit card, please complete this form and send it with your application. Payment through credit cards will not be processed without this authorization form.

Name: (applicant fees being paid for)		
Mailing Address: (applicant fees being paid for)		
City:	State:	Zip Code:
County:		Telephone #: () -
Name of cardholder: (if other than applicant)		
Mailing Address: (if other than applicant)		
City:	State:	Zip Code:

I authorize the State of Maine, Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my:

Visa MasterCard _____

Card number

Expiration date: ____/____/____ in the amount of: \$ _____

Signature: _____ Date: ____/____/____



PRINTED ON RECYCLED PAPER

PHONE: (207)624-8689
 (Office Phone)

(207)624-8563 (TTY/HEARING IMPAIRED)

FAX: (207)624-8637



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ACCOMMODATION REQUEST FORM

The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission

Name: _____

Address: _____

Telephone #: _____ Social Security Number: _____

Accommodations Requested for the _____ Examination.

Disability _____

Please check all that apply:

- Accessible Testing Site**
- Separate Testing Site**
- Braille**
- Large Print**
- Tape**
- Reader as Accommodation for Visual Impairment**
- Scribe/Amanuensis as Accommodation for Visual or Motor Impairment**
- Reader as Accommodation for Learning Disability**
- Scribe/Amanuensis as Accommodation for Learning**
- Sign Language Interpreter**
- Extended Time**
 - Time-and-a-half**
 - Double time**
 - More than double time (specify) _____**
- Use of Computer or Other Adaptive Equipment (specify) _____**
- Other: _____**

Signed and Dated:

DOCUMENTATION OF DISABILITY RELATED NEEDS

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (education professional, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since _____ in my capacity as
a **(Test applicant)** **(date)**

(professional title)

The applicant has discussed with me the nature of the test to be administered. It is my opinion that because of this applicant's disability, providing the following should accommodate him/her: (check all types)

- Taped test**
 - Large print test**
 - Reader**
 - Scribe/amanuensis**
 - Extended time**
 - Time-and-a-half**
 - Double time**
 - More that double time (please justify) _____**
 - Separate Testing Area**
 - Use of Computer or Other Adaptive Equipment (please specify) _____**
 - Other (please specify) _____**
-

Signed: _____ **Title:** _____

Date: _____ License # _____