



## REQUEST AN EXTENSION OF YOUR INTERN PHARMACIST LICENSE

### HOW LONG WILL IT TAKE TO PROCESS MY APPLICATION?

- Allow the Board 30 days to review your application.
- You will be notified in writing if your application is incomplete. To facilitate electronic communication, please provide an email address that you check regularly.
- Please do not contact the Board to check on the status of your application unless your application has been on file for over 45 days.
- If your check has cleared your bank, the Board has received your application.

You may apply for an extension of your intern pharmacist license if you meet **one** of the criteria listed below. Please Note: An intern pharmacist license may not exceed six years.

- If you are still enrolled in a school of pharmacy recognized by the Board and your anticipated graduation date changed or you recently graduated from a school of pharmacy.
- You are foreign educated and have submitted documentation of your FPGEC certificate, and you have not yet completed the required 1,500 intern hours required to apply to sit for the pharmacist examinations.
- You have failed the North American Pharmacist Licensure Examination (NAPLEX) and/or the California Practice Standards and Jurisprudence Examination for Pharmacists (CPJE) four-times and you are enrolled in remedial pharmacy educational courses to satisfy the four-time failure requirement.

The Board will notify you via email if your intern pharmacist license was approved for an extension. Your license expiration date will be reflected on the Board's website at [www.pharmacy.ca.gov](http://www.pharmacy.ca.gov) and select "Verify a License" and enter in the intern pharmacist license the Board originally issued. Please allow four to six weeks from the date a license is issued to receive the license in the mail. The Board will notify you by mail if you did not qualify for an extension of your intern pharmacist license.

### WHAT MAKES AN APPLICATION COMPLETE

Please review 1-10 to ensure your application is complete before mailing it to the Board.

- If your application is not complete, you will receive a "Deficiency Notice" via email.
- 1. APPLICATION FEE IS \$230:** When you send your application, include a check or money order made payable to the California State Board of Pharmacy. The application fee is non-refundable.
  - 2. APPLICATION FOR REGISTRATION AS AN INTERN PHARMACIST (form 17A-17):** Complete the entire application. It is preferable to complete the application online, print, then sign (wet signature) and date the application. To facilitate electronic communication, please provide an email address. To facilitate electronic communication, please provide an email address that you check regularly.
  - 3. U.S. SOCIAL SECURITY NUMBER OR INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER (ITIN):** You are required to disclose your U.S. social security number or Individual Taxpayer Identification Number (ITIN).

4. **PHOTO:** Attach a passport-style photo to page 1 of the application (2"x2" glossy, colored photo) taken within 60 days of filing the application. **DO NOT provide scanned images, Polaroids, or black-and-white photos.**
5. **MILITARY EXPEDITE:** The Board will expedite review of an application that meets one of the following criteria (A or B).
- A. **Military Veteran:** Have you ever served as an active duty member of the United States military and been honorably discharged?
- ✓ Please attach a copy of your DD214 with your application.
- B. **Active-Duty Military Spouse or Domestic Partners:** (The application fee is waived for military spouse applicants who meet the requirements that follow.) If you are married to, or in a domestic partnership or other legal union with, an active duty member of the United States military, who is assigned to a duty station in California under official active duty military orders and you hold a current license in another state, district, or territory of the United States in the profession for which you seek licensure, please provide the following:
- ✓ A copy of your current license in another state, district, or territory of the United States documenting the profession or vocation for which you seek licensure from the Board.
  - ✓ A copy of the marriage certificate, certified declaration/registration of domestic partnership, or other evidence of legal union.
  - ✓ A copy of your spouse or partner's military orders establishing duty station in California.
6. **REFUGEE EXPEDITE:** The Board will expedite review of an application that meets one of the following criteria (A, B, or C). Please attach one of the items listed under acceptable documentation.
- A. Refugee pursuant to section 1157 of title 8 of the United States Code;
- B. Refugee granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to section 1158 of title 8 of the United States Code; or,
- C. Refugee with a special immigrant visa that has been granted a status pursuant to section 1244 of Public Law 110-181, Public Law 109-163, or section 602(b) of title VI of division F of Public Law 111-8.

**ACCEPTABLE DOCUMENTATION**

- Form I-94, Arrival/Departure Record, with an admission class code such as "RE" (Refugee) or "AY" (Asylee) or other information designating the person a refugee or asylee.
- Special immigrant visa that includes the of "SI" or "SQ."
- Permanent Resident Card (Form I-551), commonly known as a "Green Card," with a category designation indicating that the person was admitted as a refugee or asylee.
- An order from a court of competent jurisdiction or other documentary evidence that provides reasonable assurance that the applicant qualifies for expedited licensure.

**7. CURRENT INTERN STATUS:** Submit A, B or C below with your application.

- A. **INTERN PHARMACIST EDUCATION AFFIDAVIT** (included in 17A-17): Submit this form if you are currently enrolled in a school of pharmacy and your anticipated graduation date has changed, or you have failed the NAPLEX and/or CPJE four-times and are enrolled in a school of pharmacy to satisfy the remedial education to sit for the examination. This form must be completed by the Dean of the School of Pharmacy and submitted with your application.
- B. **GRADUATE OF SCHOOL OF PHARMACY:** If you have recently graduated from a school of pharmacy and have submitted to the Board a Pharmacist Examination for Licensure Application (17A-1), the Board will review your transcript included with the pharmacist application to verify your graduation date and degree earned to determine if you qualify for an extension. Otherwise, please request that your school of pharmacy send to the Board an official transcript noting your degree earned and date conferred.
- C. **DOCUMENTATION OF INTERN HOURS:** A total of 1,500 intern hours is required to qualify for the pharmacist examinations but does not have to be obtained in one pharmacy location. You must submit documentation of all intern hours that you have earned up to the date of submitting the intern extension application on the Pharmacy Intern Hours Affidavit (form 17A-29) to show you have not met the 1,500 hours of intern experience at the time of applying for an extension. Please submit separate forms for each pharmacy location.

Pharmacy Intern Hours Affidavit (form 17A-29): This form must be completed by the supervising pharmacist or pharmacist-in-charge documenting your pharmacy practice experience obtained in a pharmacy OR the number of hours obtained in experience substantially related to the practice of pharmacy.

- 8. LETTER OF EXPLANATION:** Provide a letter of explanation if you are NOT currently enrolled in a School of Pharmacy. The letter of explanation must include the reason(s) why you have not been able to earn intern hours and are requesting an extension of your intern pharmacist license.
- 9. SELF-QUERY REPORT:** If it has been one year since you originally submitted a sealed, original Self-Query Report from the National Practitioner Data Bank (NPDB) to the Board with your initial intern pharmacist application, you are required to submit a new Self-Query Report with the intern extension application.

Include a sealed, original Self-Query Report from the National Practitioner Data Bank (NPDB). It must be dated within 60 days of filing the application.

- Self-Query Reports that have been opened will not be accepted.
- The name on your Self-Query Report must be **EXACTLY THE SAME** as the name on your application.
- Your U.S. social security number or ITIN must be listed on your Self-Query Report.
- To request a Self-Query Report, go to the NPDB's Web site at <http://www.npdb.hrsa.gov/> or the direct link at <https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp>
- NPDB's contact number (800) 767-6732 or TDD (703) 802-9395. Their Web site has a fact sheet and answers to frequently asked questions. The Board is not able to assist you with requesting the Self-Query Report. For help, contact the NPDB directly.
- You must pay the fee directly to NPDB.
- You must submit a new Self-Query Report even if one was submitted with a previous application.

**10. FINGERPRINTS:** If your intern license has **cancelled**, you are required to have your fingerprints completed again.

- California residents must use Live Scan. Nonresidents can visit California to complete a Live Scan or submit fingerprints on cards supplied by the Board. The fingerprint cards must be processed at a location authorized to complete fingerprint cards for the DOJ/FBI (e.g. law enforcement agency) in the state the services are rendered.
- **DO NOT** complete the Live Scan service or fingerprint cards until you are ready to send in your application.
- You must submit a copy of your Live Scan receipt or two rolled fingerprint cards with your application.
- Each application requires you to complete a new Live Scan or submit rolled fingerprint cards.
- The Live Scan site may charge a processing fee.
- The Board will accept fingerprint responses only from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

Please complete and attach **ONE** of the following (A or B):

**A. California Resident: Attach a copy of your completed Live Scan receipt.** The receipt shows you completed the Live Scan.

- California residents must use Live Scan only.
- To find a Live Scan location, go to <https://oag.ca.gov/fingerprints/locations>
- Live Scan operators can make mistakes. Be proactive; make sure everything the operator keys in to their computer is correct before the operator transmits your prints to the Department of Justice.  
Make sure the following information is correct when you complete your Live Scan:
- **Type of License/Certification/Permit or Working Title:** Pharmacy Intern-Section 4114
- **Full Name:** Must be EXACTLY THE SAME as the name on your state issued driver's license or state issued identification card (Jr., II, etc., must be included). It must also be EXACTLY THE SAME as the name on your application and your Self-Query Report.
- **Date of Birth:** Must be correct.
- **Social Security Number:** Must be included and be correct, unless you have an ITIN. If you have an ITIN, enter this number in the SSN field.
- **Level of Service:** Must include both DOJ and FBI.

**B. Non-California Resident:** You may visit California and complete Live Scan. If you cannot, then you must submit two rolled fingerprint cards with your application.

- You must use fingerprint cards from the Board of Pharmacy.
- Request fingerprint cards through the Board's online services at [https://www.dca.ca.gov/webapps/pharmacy/pubs\\_request.php](https://www.dca.ca.gov/webapps/pharmacy/pubs_request.php) or email [rxforms@dca.ca.gov](mailto:rxforms@dca.ca.gov).
- Fee: Include fingerprint card processing fee of \$49 (\$32 DOJ and \$17 FBI), made payable to the Board of Pharmacy.
- You can send one check or money order for both the application processing fee and fingerprint card processing fee.
- Print legibly or type your personal information on the fingerprint cards. If your personal information is not legible and DOJ enters your information incorrectly, you will be responsible to submit new fingerprint cards and pay the \$49 fingerprint card processing fee again.

- The fingerprint cards must be processed at a location authorized to complete fingerprint cards for the DOJ/FBI (e.g. law enforcement agency) in the state the services are rendered.
- Fingerprint clearances from cards take about six weeks longer than Live Scan.
- Poor quality prints will be rejected and will cause delay because new fingerprint cards will be required.



**California State Board of Pharmacy**  
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 Sacramento, CA 95833  
 Phone: (916) 518-3100 Fax: (916) 574-8618  
 www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency  
 Department of Consumer Affairs  
 Gavin Newsom, Governor



**INTERN PHARMACIST APPLICATION**

Please read the application instructions before you complete the application. Failure to provide the required information may result in the application being considered incomplete. Attach additional sheets of paper, if necessary. The information will be used to determine if you qualify for licensure pursuant to California Business and Professions Code sections 4208 and 4209.

TAPE A COLOR PASSPORT  
 STYLE 2"X2" PHOTO  
 TAKEN WITHIN  
 60 DAYS OF THE FILING  
 OF THIS APPLICATION  
**NO POLAROID**  
**OR**  
**SCANNED IMAGES**  
 PHOTO MUST BE ON  
 PHOTO QUALITY PAPER

**Military Expedite** (Please check one of the following, if applicable)  
 **MILITARY** (Are you serving in the United States military?)  
 **VETERAN** (Have you ever served in the United States military?)  
 **ACTIVE DUTY MILITARY** (Do you have a spouse or partner serving active duty in the military?)

**Refugee Expedite** (Please check one of the following, if applicable)  
 Refugee pursuant to section 1157 of title 8 of the United States Code;  
 Refugee granted asylum by the Secretary of Homeland Security or the Attorney General of the United States pursuant to section 1158 of title 8 of the United States Code; or,  
 Refugee with a special immigrant visa that has been granted a status pursuant to section 1244 of Public Law 110-181, Public Law 109-163, or section 602(b) of title VI of division F of Public Law 111-8.

**Applicant Information** - Please Type or Print

\_\_\_\_\_

Full Legal Name - Last Name	Suffix	First Name	Middle Name
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Previous Names (AKA, Maiden Name, Alias, etc.) \_\_\_\_\_

\*Official Mailing/Public Address of Record – Street/PO BOX \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Residence Address - Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Numbers - Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Driver's License Number \_\_\_\_\_ State \_\_\_\_\_ Email Address \_\_\_\_\_

Date of Birth (Month/Day/Year) \_\_\_\_\_ \*\*US Social Security Number or ITIN \_\_\_\_\_

Have you ever been licensed in California as an intern pharmacist?  
 Yes \_\_\_ No \_\_\_ If Yes, provide the date and intern pharmacist license number \_\_\_\_\_

**THIS SECTION IS FOR BOARD USE ONLY**

App Fee: _____	Qualify Code: _____	License #: _____	Receipt #: _____
Enf. Check: _____	SQ: _____	Date issued: _____	Date Cashiered: _____
Photo: _____	FP Cards Fees/Live Scan: _____	Date expires: _____	Amount: _____
School Code: _____	DOJ Date: _____		
FPGEC: _____	FBI Date: _____		
Affidavit: _____			

**Graduate from a Foreign School of Pharmacy, provide:**

**Name(s) of University, College, or School of Pharmacy    Country    Date of Graduation    Degree**

\_\_\_\_\_

**Enrolled in or Graduated from a United States School of Pharmacy, provide:**

**Name(s) of University, College, or School of Pharmacy    Country    Date of Graduation    Degree**

\_\_\_\_\_

**License Information** List all state(s) where you are or have previously been licensed as a pharmacist, intern pharmacist, pharmacy technician, any type of designated representative, and/or other healthcare professional, including California. All licenses both active and inactive held outside of California must be verified on the Verification of Licensure in Another State (form 17A-16).

**State    License Type and Number    Active or Inactive    Issued Date    Expiration Date**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS** (Attach additional sheets of paper if necessary)

**1. California Examinations for Pharmacists**

A. Have you taken the California Practice Standards and Jurisprudence Examination for Pharmacists (CPJE) before?

Yes \_\_\_ No \_\_\_ If Yes, provide the exam date(s): \_\_\_\_\_

B. Have you passed the CPJE?

Yes \_\_\_ No \_\_\_ If Yes, provide the exam date: \_\_\_\_\_

C. Have you previously taken a California pharmacist examination and the results were withheld?

Yes \_\_\_ No \_\_\_ If Yes, provide the exam date: \_\_\_\_\_

E. Have you ever been expelled from a California pharmacist examination?

Yes \_\_\_ No \_\_\_ If Yes, provide the exam date: \_\_\_\_\_

**2. North American Pharmacist Licensure Examination (NAPLEX)**

A. Have you taken the NAPLEX?

Yes \_\_\_ No \_\_\_ If Yes, provide the exam date(s) and primary state(s): \_\_\_\_\_

B. Have you passed the NAPLEX?

Yes \_\_\_ No \_\_\_ If Yes, provide the exam date and primary state: \_\_\_\_\_

C. Have you previously taken the NAPLEX and the results were withheld?

Yes \_\_\_ No \_\_\_ If Yes, provide the date and primary state: \_\_\_\_\_

D. Have you ever been expelled from the NAPLEX?

Yes \_\_\_ No \_\_\_ If Yes, provide the date and primary state: \_\_\_\_\_

### 3. Ownership Information

- A. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator, or medical director on a license to conduct a pharmacy, wholesaler, third-party logistics provider, or any other entity licensed in any state, territory, foreign country, or other jurisdiction?

Yes \_\_\_ No \_\_\_ If Yes, attach a statement of explanation including company name, type of license, license number, and identify the state, territory, foreign country, or other jurisdiction where licensed.

### 4. Disciplinary History

The following questions pertain to a license sought or held in any state, territory, foreign country, or other jurisdiction. For any affirmative answer, attach a statement of explanation including type of license, license number, type of action, date of action, and identify the state, territory, foreign country, or other jurisdiction.

- A. Have you ever had an application for pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration denied?  
Yes \_\_\_ No \_\_\_
- B. Have you ever had a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it?  
Yes \_\_\_ No \_\_\_
- C. Have you ever had a pharmacy, wholesaler, third-party logistics provider, and/or any other entity license denied, suspended, revoked, placed on probation, or had other disciplinary action taken against a license you hold?  
Yes \_\_\_ No \_\_\_

### 5. Practice Impairment or Limitation

The board makes an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the board is unable to make a determination based on the information provided, the board may require an applicant to be examined by one or more physicians or psychologists, at the board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.

- A. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice safely?  
Yes \_\_\_ No \_\_\_ If Yes, attach a statement of explanation.
- B. Have you ever been diagnosed with a physical condition that may impair your ability to practice safely?  
Yes \_\_\_ No \_\_\_ If Yes, attach a statement of explanation.
- C. Do you have any other condition that may in any way impair or limit your ability to practice safely?  
Yes \_\_\_ No \_\_\_ If Yes, attach a statement of explanation.



- D. Have you ever participated in, been enrolled in, or required to enter into any drug, alcohol, or substance abuse recovery program or impaired practitioner program?  
Yes \_\_\_\_ No \_\_\_\_ If Yes, attach a statement of explanation.
- E. If you answered “Yes” to questions listed under 5 (A through D) above, have you ever received treatment or participated in any program that improves your ability to practice safely?  
Yes \_\_\_\_ No \_\_\_\_ N/A \_\_\_\_ If Yes, attach a statement of explanation.

**Reminder:** The Self-Query Report by the National Practitioner Data Bank (NPDB) must be submitted with your application.

### **APPLICANT AFFIDAVIT**

You must provide a written explanation for all affirmative answers. Failure to provide any of the requested information may result in the application being deemed incomplete. Falsification of the information on this application may constitute grounds for denial or revocation of the license. Any application not completed within one year after being notified by the board of deficiencies may be deemed to have been abandoned, and the applicant will be required to file a new application and meet all the requirements that are in effect at the time of application. Fees applied to this application are not transferable or refundable.

**Collection and Use of Personal Information.** The California State Board of Pharmacy of the Department of Consumer Affairs collects the personal information requested on this form pursuant to Business and Professions Code sections 30 and 4000 and following and California Code of Regulations title 16, division 17. The California State Board of Pharmacy uses this information principally to identify and evaluate applicants for licensure, issue, and renew licenses, and enforce licensing standards set by law and regulation.

**Access to Personal Information.** You may review the records maintained by the California State Board of Pharmacy that contain your personal information, as permitted by the Information Practices Act. The official responsible for maintaining records is the Executive Officer at the board’s address listed on the application. Each individual has the right to review the files or records maintained by the board, unless confidential and exempt by law.

**Possible Disclosure of Personal Information.** We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed under the following circumstances:

- In response to a Public Records Act request (Government Code section 6250 and following), as allowed by the Information Practices Act (Civil Code section 1798 and following);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

**\*Address of Record:** Once you are licensed with the board, the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 and following) and the Public Records Act (Government Code section 6250 and following) and will be available on the Internet. This is where the board will mail all official correspondence. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your address of record is not your residence address, you must also provide your residence address to the board, in which case your residence will not be available to the public.

**\*\*Disclosure of your U.S. Social Security Number or Individual Taxpayer Identification Number (ITIN) is mandatory.** Section 30 of the Business and Professions Code, section 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security number or individual taxpayer identification number. Your social security number or individual taxpayer identification number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code, or for verification of license or examination status by a licensing or examination entity, which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or individual taxpayer identification number, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

NOTICE: The State Board of Equalization and the Franchise Tax Board may share taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if your state tax obligation is not paid.

### **MANDATORY REPORTER**

Under California law, each person licensed by the California State Board of Pharmacy is a “mandated reporter” for both child and elder abuse or neglect laws. California Penal Code section 11166 and Welfare and Institutions Code section 15630 require that all mandated reporters make a report to an agency specified in Penal Code section 11165.9 and Welfare and Institutions Code section 15630(b)(1) [generally law enforcement, state, and/or county adult protective services agencies, etc.] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child, elder, and/or dependent adult whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or elder abuse or neglect. The mandated reporter must contact by telephone immediately or as soon as possible to make a report to the appropriate agency(ies) or as soon as is practicably possible. The mandated reporter must prepare and send a written report thereof within two working days or 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of the laws above is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars (\$1,000), or by both that imprisonment and fine. For further details about these requirements, refer to Penal Code section 11164 and Welfare and Institutions Code section 15630 and following sections.

### **APPLICANT AFFIDAVIT (must be signed and dated by the applicant)**

I, \_\_\_\_\_, hereby attest to the fact that I am the  
(Print Full Legal Name)

applicant whose signature appears below. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers, and representations made in this application, including all supplementary statements. I understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

\_\_\_\_\_  
Original Signature of Applicant  
(please sign and date within 60 days of board receipt of the application)

\_\_\_\_\_  
Date



**California State Board of Pharmacy**  
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 Sacramento, CA 95833  
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 www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency  
 Department of Consumer Affairs  
 Gavin Newsom, Governor



## INTERN PHARMACIST EDUCATION AFFIDAVIT

**Instructions:** This form must be completed by the dean of the school of pharmacy.

This is to certify that \_\_\_\_\_  
Print Name of Applicant

who is applying to the California State Board of Pharmacy for an intern pharmacist license is: (check one)

\_\_\_\_ Enrolled as a student in this institution and is seeking a degree in pharmacy.

\_\_\_\_ Re-enrolled to take additional coursework prior to re-examination by the board.

Year enrolled in school \_\_\_\_\_ Expected date of graduation \_\_\_\_\_  
Month/Year Month/Year

I hereby certify as the dean of the school of pharmacy listed below or as a person with authority and personal knowledge under penalty of perjury under the laws of the State of California to the truth and accuracy of the above:

Signed: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 College, University, or School of Pharmacy

\_\_\_\_\_  
 Street Address City State Zip Code

\_\_\_\_\_  
 Print Name of Dean or Person of Authority and Personal Knowledge of these Facts Title

\_\_\_\_\_  
 Phone Number Email Address

**Affix School Seal Here**



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**VERIFICATION OF LICENSE IN ANOTHER STATE**

This form must be completed by the licensing agency in each state you hold or held an individual license (e.g. pharmacist, intern pharmacist, pharmacy technician, designated representative, and/or another healthcare professional license) even if the license is no longer current or active. Please return the original state-verified form with your application for each license type. Photocopies or faxes will not be accepted.

Intern hours and licensure earned in another state may be certified by the licensing agency in each state you earned your intern hours or license on this form.

The licensee listed on this form has applied for a license in California. Before further consideration is given to this application, the California State Board of Pharmacy would appreciate your assistance in completing the information requested below. Upon completion of this form, please return it to the applicant for submission with the application.

**Completed by Licensee** \_\_\_\_\_  
 Licensee's Full Name License Number

**Completed by the State Licensing Board or Agency Verifying Licensure**

Licensure Verification Provided by the State of	License Type and License Number	Issued Date	Expiration Date	Intern Hours Earned in this State under this Intern License

License Status (Please check one) – Active \_\_\_\_\_ Inactive \_\_\_\_\_ Other \_\_\_\_\_ If other, please explain \_\_\_\_\_

Has this agency taken any disciplinary action against this license? Yes \_\_\_\_\_ No \_\_\_\_\_

If disciplinary action has been taken against this licensee, please directly provide this office with the accusation/proposed charges and decision/final order regarding the action.

I hereby certify the information listed above is true and correct.

\_\_\_\_\_  
 Printed Name

Board Seal

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Title Date

**INSTRUCTIONS FOR COMPLETING A  
"REQUEST FOR LIVE SCAN SERVICE" FORM**

**California Live Scan**

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly.

**NOTE TO APPLICANT/LICENSEE and LIVE SCAN OPERATOR:** The name, date of birth and US Social Security Number (SSN) must be entered in at the time of the Live Scan transmission for the results to be accepted by the California State Board of Pharmacy. If the name, date of birth or SSN is not entered at the time of Live Scan transmission, the individual may have to have a new Live Scan transmission completed.

**Type of License/Certification or Permit or Working Title:** The Live Scan operator must enter in the Type of License that is specified on the Request for Live Scan Service form.

**Applicant Information:**

- **Name:** Enter your last name, first name and middle name that matches your government issued driver's license or state identification. Do not use initials or name abbreviations. Your legal name must be on file with the board. If your name has changed you are required to notify the board within 30 days of the change.
- **Other Name (AKA):** Enter all other names you have used, including your maiden name.
- **Date of Birth:** (month/day/year).
- **SEX:** Mark the appropriate gender box (male or female)
- **Driver's License Number:** Driver's License Number.
- **Height:** Your height in feet and inches.
- **Weight:** Your weight in pounds.
- **Eye Color:** Color of your eyes
- **Hair Color:** Color of your hair
- **Place of Birth:** Enter your place of birth
- **Social Security Number:** Must be included and be correct, unless you have an ITIN. If you have an ITIN, then this field should be left blank.
- **Misc. Number:** Other identification number
- **Home Address:** Your residence address

**Level of Service:** This has already been preselected for you. You are required to have both DOJ and FBI level of service complete. Please ensure at the time of Live Scan transmission that the Live Scan operator selects both the DOJ and FBI levels of service in their computer system. If FBI is not selected at the time of original transmission, you will be required to have your Live Scan redone at another time and repay for the DOJ and FBI levels of services again. The board has been notified by the DOJ that effective 9/1/07, if the FBI level of service is not requested at the time of original transmission both DOJ and FBI levels of service will have to be redone. Any issue of cost for resubmission should be handled at the Live Scan Site level.

**Employer:** This information is not required.

**Take the completed form** to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at <https://oag.ca.gov/fingerprints/locations> or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (DOJ processing fee of \$32, FBI processing fee of \$17, and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about \$5 to \$20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs. The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

#### **FINGERPRINTING AUTHORITY**

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required for the DOJ/FBI to conduct background checks for criminal convictions.

**INSTRUCTIONS FOR COMPLETING A  
"REQUEST FOR LIVE SCAN SERVICE" FORM**

**California Live Scan**

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly.

**NOTE TO APPLICANT/LICENSEE and LIVE SCAN OPERATOR:** The name, date of birth and US Social Security Number (SSN) must be entered in at the time of the Live Scan transmission for the results to be accepted by the California State Board of Pharmacy. If the name, date of birth or SSN is not entered at the time of Live Scan transmission, the individual may have to have a new Live Scan transmission completed.

**Type of License/Certification or Permit or Working Title:** The Live Scan operator must enter in the Type of License that is specified on the Request for Live Scan Service form.

**Applicant Information:**

- **Name:** Enter your last name, first name and middle name that matches your government issued driver's license or state identification. Do not use initials or name abbreviations. Your legal name must be on file with the board. If your name has changed you are required to notify the board within 30 days of the change.
- **Other Name (AKA):** Enter all other names you have used, including your maiden name.
- **Date of Birth:** (month/day/year).
- **SEX:** Mark the appropriate gender box (male or female)
- **Driver's License Number:** Driver's License Number.
- **Height:** Your height in feet and inches.
- **Weight:** Your weight in pounds.
- **Eye Color:** Color of your eyes
- **Hair Color:** Color of your hair
- **Place of Birth:** Enter your place of birth
- **Social Security Number:** Must be included and be correct, unless you have an ITIN. If you have an ITIN, then this field should be left blank.
- **Misc. Number:** Other identification number
- **Home Address:** Your residence address

**Level of Service:** This has already been preselected for you. You are required to have both DOJ and FBI level of service complete. Please ensure at the time of Live Scan transmission that the Live Scan operator selects both the DOJ and FBI levels of service in their computer system. If FBI is not selected at the time of original transmission, you will be required to have your Live Scan redone at another time and repay for the DOJ and FBI levels of services again. The board has been notified by the DOJ that effective 9/1/07, if the FBI level of service is not requested at the time of original transmission both DOJ and FBI levels of service will have to be redone. Any issue of cost for resubmission should be handled at the Live Scan Site level.

**Employer:** This information is not required.

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## REQUEST FOR LIVE SCAN SERVICE

### Applicant Submission

ORI (Code assigned by DOJ)

Authorized Applicant Type

Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

### Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

City State ZIP Code

Contact Telephone Number

### Applicant Information: **Live Scan Operator – The Board of Pharmacy requires you to enter the applicant's SSN.**

Last Name First Name Middle Initial Suffix

Other Name (AKA or Alias) Last First Suffix

Date of Birth Sex  Male  Female

Driver's License Number

Height Weight Eye Color Hair Color

Billing Number (Agency Billing Number)

Place of Birth (State or Country) Social Security Number - **MANDATORY**

Misc. Number (Other Identification Number)

Home Address Street Address or P.O. Box

City State ZIP Code

Your Number: OCA Number (Agency Identifying Number)

Level of Service:  DOJ  FBI

If re-submission, list original ATI number:  
(Must provide proof of rejection)

Original ATI Number

### Employer (Additional response for agencies specified by statute):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City State ZIP Code

Telephone Number (optional)

### Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency LSID

ATI Number Amount Collected/Billed