

**DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292**



**PHARMACY INTERN APPLICATION
FOR U.S. PHARMACY STUDENTS/GRADUATES
AND INSTRUCTIONS**

SEPTEMBER 2009



Dear Florida Pharmacy Internship Applicant,

Thank you for applying for licensure as an Intern in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the board) staff to process your application as soon as possible. You are encouraged to apply as early as possible, to avoid delays due to a large volume of applicants.

Florida Statutes require a completed application before your application can be reviewed. You should use the enclosed checklist to ensure that all sections of the application are complete and that the required forms are submitted. Please read these instructions carefully and fully before submitting the application. You should keep a copy of the completed application and all other materials sent to the board office for your records. When you mail the completed application, use the address noted in the instructions and on the application form. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the board staff, you are encouraged to email the board staff at mqa_pharmacy@doh.state.fl.us, or you may call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

Executive Director
Board of Pharmacy

GENERAL INFORMATION

Application Processing

Please read all application instructions before completing your application.

Within 30 days of receipt of your application, the board office will notify you of the receipt of your application, any required documents, and your status. In order to complete your application, please return the following with your application:

- 1) A copy of your U.S. social security card. The only acceptable social security cards are those issued by the Social Security Administration. **A card that is not valid for employment is NOT acceptable.** The following are the only types of cards that will be accepted:
 - a) A social security card that shows your name and social security number only, or
 - b) A social security card that shows your name and social security number with the legend, "VALID FOR WORK ONLY WITH INS AUTHORIZATION."

To obtain more information, or to apply for a social security number and card, you may contact the Social Security Administration at (800) 772-1213 or www.socialsecurity.gov, or you may visit your local office.

- 2) One passport-type photo (2x2 facial photo) taken within the last six months with your signature on the back.
- 3) Social Security form (enclosed).

PLEASE BE ADVISED THAT ALL INCOMPLETE APPLICATIONS EXPIRE ONE YEAR AFTER RECEIPT. IF YOUR APPLICATION EXPIRES, YOU WILL HAVE TO REAPPLY AND RESUBMIT ALL DOCUMENTS.

IMPORTANT NOTICE: Effective July 1, 2009, section 456.0635, Florida Statutes, provides that health care boards or the department shall refuse to issue a license, certificate or registration and shall refuse to admit a candidate for examination if the applicant has been:

1. Convicted or plead guilty or nolo contendere to a felony violation of: chapters 409, 817, or 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss 1395-1396, unless the sentence and any probation or pleas ended more than 15 years prior to the application.
2. Terminated for cause from Florida Medicaid Program (unless the applicant has been in good standing for the most recent five years).
3. Terminated for cause by any other State Medicaid Program or the Medicare Program (unless the termination was at least 20 years prior to the date of the application and the applicant has been in good standing with the program for the most recent five years).

If applicable to you, please provide the documentation to the department.

REQUIREMENTS FOR FLORIDA INTERNSHIP

Please submit the following to the Florida Board of Pharmacy:
P.O. Box 6320, Tallahassee, FL 32314-6320

ITEM #1 – Social Security Form: Under the Federal Privacy Act, disclosure of Social Security Numbers is voluntary unless specifically required by federal statute. **In this instance, Social Security Numbers are mandatory pursuant to Title 42 United States Code, Sections 653 and 654; and sections 456.013(12), 409.2577, and 409.2598, Florida Statutes.** Social Security Numbers are used to allow efficient screening of applicants and licensees by a Title IV-D child support agency to assure compliance with child support obligations. Social Security Numbers must also be recorded on all professional and occupational license applications and will be used for licensee identification pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act), 104 Pub. L. 193, Section 317. **Please attach to Item #2 (Florida Pharmacy Intern Application) with a copy of your Social Security Card.**

ITEM #2 – Pharmacy Intern Application for U.S. Pharmacy Students/Graduates: All sections must be completed in full. If you answer “yes” to any of the questions in 5-12 on the application, please submit certified official court copies of any supporting documents for the board to review. If an item is not applicable, indicate with N/A. N/A is not an acceptable answer for yes or no questions and could result in a delay of processing. Failure to submit a complete application will result in a delay of processing. If you provide false information, the board may deny your application for licensure. **Please attach a 2x2 facial photo on the first page of the application.**

APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation to the board, will result in an incomplete application. **Final approval cannot be granted until the application is complete.** Faxed applications will not be accepted.

_____ **Social Security Form (Item #1) – (Attach to Item #2)**

_____ **Copy of Social Security Card attached.**

_____ **Pharmacy Intern Application for U.S. Pharmacy Students/Graduates (Item #2)**

_____ **2”x2” photograph attached.**

_____ **HEALTH HISTORY:** All applicants for licensure must complete this section on the application. Supporting documentation related to any “Yes” answer must be submitted to the Board of Pharmacy, 4052 Bald Cypress Way, Bin C-04, Tallahassee, FL 32399-3252. (see application for further instructions)

_____ **CRIMINAL HISTORY:** (See Question & Answers Regarding Prior Criminal History & Disciplinary Actions)



FLORIDA BOARD OF PHARMACY
P.O. Box 6320 • Tallahassee, FL 32314-6320
Phone: (850) 245-4292 www.doh.state.fl.us/mqa/pharmacy

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Name: _____
 Last **First** **Middle**

Social Security Number: _____

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Please attach a 2x2 photo here

(Please do not staple photo to application)



FLORIDA BOARD OF PHARMACY
 P.O. Box 6320 • Tallahassee, FL 32314-6320
 Phone: (850) 245-4292
 www.doh.state.fl.us/pharmacy/drugs

**ITEM #2 – PHARMACY INTERN APPLICATION
 FOR U.S. PHARMACY STUDENTS/GRADUTES**

Rule 64B16-26.400(1), Florida Administrative Code, states, A pharmacy intern is required to be registered with the Department of Health as an intern before being employed as an intern in a pharmacy in Florida. Intern certificates issued by the Florida Board of Pharmacy (the board) are valid for the State of Florida ONLY and must be returned to the board after an intern has become a Registered Pharmacist in the State of Florida. Applicants must complete the information below and forward the application to the College of Pharmacy to be completed by the Dean and returned to the address above.

Please print or type legibly.

1. Biographical Information			
Last Name	First Name		Middle Name
Home Address (Mailing Address – ML)	City	State	Zip
Work Address (Practice Location – PL)	City	State	Zip
Current Phone Number	Home Phone Number	Date of Birth	
2. Equal Opportunity Data – We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43FR38295 (August 25, 1978). The information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.			
SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female			
RACE: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other			
3. If known, indicate the name and address of the pharmacy where you will intern in Florida.			
4. Have you ever applied to take the Florida pharmacist examination? If yes, please indicate the date.			
Yes _____ No _____ Date _____			
5. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest, to a crime in any jurisdiction other than a minor traffic offense?			
Yes _____ No _____			
(You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction. Driving under the influence or driving while impaired is <u>NOT</u> a minor traffic offense for the purposes of this question.)			

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6. In the last five (5) years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

Yes _____ No _____

7. In the last five (5) years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

Yes _____ No _____

8. During the last five (5) years, have you been treated for or had a recurrence of a diagnosed physical impairment that has impaired your ability to practice pharmacy?

Yes _____ No _____

9. In the last five (5) years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five (5) years?

Yes _____ No _____

10. Has disciplinary action ever been taken against your pharmacist or any other professional license in this state or any other state?
Yes _____ No _____
11. Have you ever surrendered your pharmacist or any other professional license in another jurisdiction when disciplinary action was pending?
Yes _____ No _____
12. Are you presently being investigated or is any disciplinary action pending against you?
Yes _____ No _____
13. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396? (If no, do not answer 13b.)
Yes _____ No _____
13b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?
Yes _____ No _____
14. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 14b.)
Yes _____ No _____
14b. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years?
Yes _____ No _____
15. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 15b and 15c.)
Yes _____ No _____
15b. Have you been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?
Yes _____ No _____
15c. Did the termination occur at least 20 years prior to the date of this application?
Yes _____ No _____

All of the above questions must be answered or your application will be returned for completion. If you answer "yes" to any questions in 5-15c, explain on a sheet providing accurate details, and submit a certified official copy of the order of the court or state board of pharmacy, supporting documents or all if applicable.

(SIGNATURE OF APPLICANT)

(DATE)

12. TO BE COMPLETED BY DEAN OF COLLEGE OF PHARMACY

This is to certify that the above named applicant is entered into the professional curriculum of the

_____, as of _____; and is a graduate
(NAME OF SCHOOL) (DATE)

of said professional curriculum as of _____.
(DATE)

(SCHOOL SEAL)

(PRINT NAME OF DEAN)

(SIGNATURE OF DEAN)

(DATE)

Frequently Asked Questions

Question: What crimes or license discipline must be reported on the application?

Answer: All convictions, guilty pleas, and nolo contendere pleas must be reported, except for minor traffic violations not related to the use of drugs or alcohol. This includes misdemeanors, felonies, “driving while intoxicated (DWI)” and “driving under the influence (DUI).” Crimes must be reported even if they are a suspended imposition of sentence. All prior disciplinary action against any other professional licenses must be reported, whether it occurred in Florida or another state or territory.

Question: Can a person obtain a license as a pharmacist if they have a misdemeanor or felony crime on their record?

Answer: Each application is evaluated on a case-by-case basis. The board considers the nature, severity, and recency of offenses, as well as rehabilitation and other factors. The board cannot make a determination for approval or denial of licensure without evaluating the entire application and supporting documentation.

Question: Do I have to report charges if I completed a period of probation and the charges were dismissed or closed?

Answer: Yes. Offenses must be reported to the board even if you received a suspended imposition of sentence and the record is now considered closed.

Question: What type of documentation do I need to submit in support of my application if I have a prior criminal record or licensure discipline?

Answer: (1) Certified official court document(s) relative to your criminal record, showing the date(s) and circumstance(s) surrounding your arrest(s)/conviction(s), section(s) of the law violated, and disposition of the case. This would normally consist of the Complaint or Indictment, the Judgment, Docket Sheet or other documents showing the disposition of your case. This may also be referred to as the Order of Probation. The clerk of court must certify these documents.

(2) Certified copy of document(s) relative to any disciplinary action taken against any license. The documents must come from the agency that took the disciplinary action and must be certified by that agency.

(3) A detailed description of the circumstances surrounding your criminal record or disciplinary action and a thorough description of the rehabilitative changes in your lifestyle since the time of the offense or disciplinary action, which would enable you to avoid future occurrences. It would be helpful to include factors in your life, which you feel may have contributed to your crime or disciplinary action, what you have learned about yourself since that time, and the changes you have made that support your rehabilitation.

Question: How do I record my intern hours?

Answer: Intern hours are recorded on the Internship or Work Experience Form (Form B), DH-MQA 1104, Effective June 2007. This form is located in the Pharmacist Licensure by Examination and Pharmacist Licensure by Endorsement applications on the board website at www.doh.state.fl.us/mqa/pharmacy.

Question: What laws and rules govern pharmacy interns?

Answer: Florida pharmacy interns are governed by 465.0075, *Florida Statutes*, and 64B16-26.400 and 64B16-26.2032, *Florida Administrative Code*. Please download a copy of the laws and rules from the board website at www.doh.state.fl.us/mqa/pharmacy.

FLORIDA BOARD OF PHARMACY INTERNSHIP REGISTRATION INFORMATION

If you are enrolled in a College of Pharmacy in the State of Florida, please be advised that upon receipt of the certification of graduation, the State Board will verify completion of 2080 hours.

If you are a graduate of an out of state college, the State Board can only certify hours that have been recorded in your file on the attached intern affidavit form. The Florida Board of Pharmacy accepts a PharmD. Degree as completion of the internship requirement for licensure in Florida. When you request our office to verify your intern hours we will send the intern affidavit to the State of your choice. There is a \$25.00 fee to process this information.

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Please type or print legibly

INTERN AFFIDAVIT REPORT

Name of Intern _____ Intern Number _____

Address _____
Street City State Zip

Have you submitted an application for the Florida Pharmacist Licensure exam? YES _____ NO _____

If so, please indicate exam date: Month _____ Year _____

I hereby apply for internship credit as outlined below worked under the supervision of:

Pharmacist's Name _____ License Number _____

Name of Pharmacy _____ Permit Number _____

Address _____
Street City State Zip

Intern's Signature _____

Date _____

Week Beginning			Week Ending			Total Hours
Per Week						
Mo	Day	Year	Mo	Day	Year	

Week Beginning			Week Ending			Total Hours
Per Week						
Mo	Day	Year	Mo	Day	Year	

I hereby certify this report is a correct statement of fact. The above information was taken from the records of the above named pharmacy and are available for inspection by the Board of Pharmacy. I also certify these hours were completed outside of the hours required by the College of Pharmacy.

Preceptor/Supervisor's Signature _____ Date _____

Name of Pharmacy _____ Permit Number _____

Address _____

Street

City

State

Zip

Phone: _____
