

Limited-Use Pharmacy Technician Registration Application



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**APPLICATION FOR REGISTRATION AS A
LIMITED-USE PHARMACY TECHNICIAN**
For use exclusively in a free clinic

INSTRUCTIONS

1. Applicants must complete all sections.
2. Completed application and fee must be mailed to the above address.

I. GENERAL INFORMATION

Name: Last	First	Middle/Maiden		
Street Address (official address of record**)	City	State	Zip Code	Telephone Number
Street Address (public address of record)	City	State	Zip Code	Telephone Number
Date of Birth ____/____/____	Social Security Number or Virginia DMV Control Number			
Email Address	NABP E-Profile ID Number			

**In accordance with § 54.1-2400.02 of the Code of Virginia, an applicant must provide an official address of record. An applicant may choose to provide a second address for public dissemination, which may be a work address, a post office box, or a home address. If an applicant does not provide a second address, his official address of record shall also be used as the public address for the purpose of public dissemination.

II. NATIONAL EXAM CERTIFICATION

National Certification from National Healthcareer Association (NHA), or Pharmacy Technician Certification Board (PTCB)	YES <input type="checkbox"/> National Certification Number: _____ Exp Date: _____	NO <input type="checkbox"/>
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FOR OFFICE USE ONLY

Application Number	Registration Number	Date Issued	Other
02 _____	0231 _____		

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III. TRAINING PROGRAM INFORMATION

AND

Completion of Board-Approved Pharmacy Technician Training Program OR	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Completion of jointly accredited ASHP/ACPE Pharmacy Technician Training Program OR	YES <input type="checkbox"/> A copy of the certificate of completion from the training program must accompany this application.	NO <input type="checkbox"/>
Completion of Accredited Pharmacy Technician Training Program operated through the Department of Education's Career and Technical Education Program OR	YES <input type="checkbox"/> A copy of the certificate of completion from the training program must accompany this application.	NO <input type="checkbox"/>
Completion of Pharmacy Technician Training Program operated through a federal agency or branch of the military OR	YES <input type="checkbox"/> A copy of the certificate of completion from the training program must accompany this application.	NO <input type="checkbox"/>
Completion of Pharmacy Technician Training Program accredited by an accreditation body approved by the Board OR	YES <input type="checkbox"/> A copy of the certificate of completion from the training program must accompany this application.	NO <input type="checkbox"/>
Completed or was enrolled in a Board-approved Pharmacy Technician Training Program prior to 7/1/2022 but did not pass exam until after 7/1/2022. OR	YES <input type="checkbox"/> Enter the name of training program below. _____	NO <input type="checkbox"/>
Passed a National exam prior to 7/1/2022, but did not complete a Board-approved Pharmacy Technician Training Program prior to 7/1/2022 OR	YES <input type="checkbox"/> Enter the name of training program below. _____	NO <input type="checkbox"/>
No Pharmacy Technician Training Program completed, but have practiced in another state	State: _____ Dates of Practice: _____	

IV. ADDITIONAL LICENSURE, CERTIFICATION, OR REGISTRATION: List all states or other jurisdictions in which you have ever held a license, certification or registration as a pharmacy technician (use extra paper if necessary).

STATE	NUMBER	EXPIRATION DATE

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V. ANSWER THE FOLLOWING QUESTIONS: Attach additional page if needed as well as any related documents

		YES	NO
1.	<p>Have you ever been denied a pharmacy technician license, certification, or registration? If yes, state where, explain the reason, and attach any related documents:</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<p>Have you ever had disciplinary action against your pharmacy technician license, certification, or registration in any other jurisdiction, or have been prohibited from performing the duties of a pharmacy technician by any other state, or prohibited by a health regulatory board of any state or by any federal agency from practicing, or assisting in the practice of, any health profession? If yes, what jurisdiction and date, explain, and attach any official documents related to your case.</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<p>Have you ever been convicted of a violation of local, state or federal statute, regulation or ordinance, or entered into any plea agreement relating to a felony or misdemeanor? (Exclude traffic violations, except convictions for driving under the influence and reckless driving). If yes, what jurisdiction and date where charged or convicted, explain, and attach copies of any official documents such as warrants and court orders showing the nature and disposition of such charges or convictions. Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed.</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<p>Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? If yes, provide full explanation including if you have been directed to seek treatment for your conduct or behavior.</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<p>Within the past five years, have you been disciplined by any entity? If yes, please provide a full explanation and any associated orders or letters from entity.</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<p>Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? “Currently means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Technician. If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board.</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/>	<input type="checkbox"/>

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		YES	NO
7.	Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Technician. If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
8.	Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Technician? If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board	<input type="checkbox"/>	<input type="checkbox"/>
9.	Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? If yes, please provide a full explanation and any associated orders or letters from the entity. NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider requesting your provider send this documentation directly to the Board.	<input type="checkbox"/>	<input type="checkbox"/>
10.	Are you a spouse of someone who is on federal active duty orders pursuant to Title 10 of the U. S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Are you active duty military?	<input type="checkbox"/>	<input type="checkbox"/>

VI. APPLICANT’S STATEMENT (The following statement must be signed)

I, _____ hereby certify and affirm that the statements contained
 (Print Name)
 in this application for registration as a limited-use pharmacy technician in the Commonwealth of Virginia are true and accurate in every respect. I hereby make application for registration as a **Limited-Use Pharmacy Technician** in the Commonwealth of Virginia. The following evidence of my qualifications is submitted. I understand that I may not work as a pharmacy technician in a pharmacy other than a free clinic pharmacy with this limited registration.

Signature of applicant	Date