Reset Form

APPLICATION FOR PHARMACIST INTERN REGISTRATION

State Form 12567 (R17 / 7-22)

INDIANA BOARD OF PHARMACY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov
www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application is $10.00, payable to the Indiana Professional Licensing Agency, in accordance with 856 IAC 1-27-1.*
2. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
3. *All fees are non-refundable and non-transferable.*
4. *Please refer to the instructions on our website, www.pla.in.gov, for the licensing requirements.*

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is mandatory and this record cannot be processed without it.
** This information is being requested for workforce statistical purposes only; disclosure is voluntary.

FOR OFFICE USE ONLY	
APPLICATION / PERMIT FEE	
DATE FEE PAID *(month, day, year)*	
RECEIPT NUMBER	
PERMIT NUMBER ISSUED	
DATE OF ISSUANCE *(month, day, year)*	

DO NOT WRITE ABOVE THIS LINE

INFORMATION ABOUT THE APPLICANT

Name of applicant *(last, first, maiden)*

Social Security Number*

Address *(number and street or rural route number)*

City, state, and ZIP code

Date of birth *(month, day, year)*

Gender ** ☐ Male ☐ Female

Telephone number *(daytime)*
( )

Email address

Pursuant to IC 12-32-1-5 and IC 12-32-1-6, I swear under the penalty of perjury that: *(Please select one of the following.)*

☐ I am a United States Citizen. ☐ I am a qualified alien (as defined under 8 U.S.C. § 1641). ☐ I am authorized by the Federal Government to work in the United States.

Are you the spouse of a member of the military who is assigned to a duty station in Indiana? *(Optional)* ☐ Yes ☐ No

Are you an active duty member of the military? *(Optional)* ☐ Yes ☐ No

Are you enrolled in a college of pharmacy? ☐ Yes ☐ No

If "Yes", where?

If "No", do you plan to enroll in or are you a graduate of a college of pharmacy? ☐ Yes ☐ No

If "Yes", when and where?

QUESTIONS

If your answer is "Yes" to any of the following, explain fully in a signed written statement, including all related details, and provide copies of all relevant arrest or court documents. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held or are formal charges pending? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit to practice as a pharmacist intern, or any other health regulated occupation in any state? ☐ Yes ☐ No
3. Are there any charges pending against you regarding a violation of any Federal, State or Local law relating to the use, manufacturing, distribution or dispensing of controlled substances, alcohol, or other drugs? ☐ Yes ☐ No
4. Except for minor violations of traffic laws resulting in fines, and arrests or convictions that have been expunged by a court,
   (1) have you ever been arrested; ☐ Yes ☐ No
   (2) have you ever entered into a prosecutorial diversion or deferment agreement regarding any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (3) have you ever been convicted of any offense, misdemeanor, or felony in any state; ☐ Yes ☐ No
   (4) have you ever pled guilty to any offense, misdemeanor, or felony in any state; or ☐ Yes ☐ No
   (5) have you ever pled *nolo contendere* to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No
5. Do you have any condition or impairment (including a history of alcohol or substance abuse) that currently interferes, or if left untreated may interfere, with your ability to practice in a competent and professional manner? ☐ Yes ☐ No
6. Have you ever been denied the privilege to dispense and / or fill prescriptions for a third payer or government run health plan / program, or have you been denied the rights to handle of fill prescriptions for certain types of classes of drugs? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Professional Licensing Agency any files, documents, records or other information pertaining to the undersigned requested by the Agency or Board, or any of its authorized representatives in connection with processing my application for licensure.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Professional Licensing Agency to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Agency from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I affirm, under penalties for perjury, that the foregoing representations are true.

Signature of applicant	Date *(month, day, year)*

CERTIFICATE OF ENROLLMENT OR GRADUATION FOR PHARMACY INTERN

Part of State Form 12567

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Name of applicant *(last, first, middle)*	Date of birth

CERTIFICATE OF ENROLLMENT OR GRADUATION IN PHARMACY EDUCATION

NOTE TO APPLICANT: The certificate below must be completed and signed by the Secretary or Dean of the School or College of Pharmacy of which you are currently enrolled or a graduate. If you are a graduate of a School or College of Pharmacy outside of the United States, then you do not need this certificate completed; you are required to submit a notarized copy of your FPGEC Certificate.

This is to certify that _____ is enrolled / a graduate

of _____.

Name of school or college of pharmacy	City, state, and ZIP code

Number of years pharmacy	Number of years pre-pharmacy	Date *(month, day, year)*

On this day, I certify that the applicant named herein is enrolled in a college of pharmacy and will be entering an externship program. Within the program, the applicant will be filing and compounding prescriptions under the direct supervision of a licensed pharmacist in a licensed pharmacy.

(SEAL)	Signature of Secretary or Dean

SPONSOR AFFIDAVIT FOR PHARMACY INTERN

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SPONSOR'S STATEMENT AND AFFIDAVIT

To the Indiana Board of Pharmacy: I, _____, of _____

County of _____, State of Indiana, do hereby make the following statement for the benefit of

_____ who is an applicant for registration as a pharmacist intern.

Name of Indiana Licensed Pharmacist	License number
Place of employment	Pharmacy permit number
Address *(number and street, city, state, and ZIP code)*	

On this day, I certify that I am a licensed pharmacist holding the license number listed above in Indiana and that the above named pharmacist intern will be in my employ, compounding, and filling prescriptions for medical practitioners under my supervision at the above named pharmacy.

I solemnly swear or affirm that the statements given above are true and correct to the best of my knowledge.

Signature of Indiana Licensed Pharmacist	Date *(month, day, year)*