Reset Form

APPLICATION FOR A PHARMACIST LICENSE

State Form 36028 (R20 / 12-21)
Approved by State Board of Accounts, 2017

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 the initial application is $100.00, payable to the Indiana Professional Licensing Agency, in accordance with 856 IAC 1-27-1.*
2. *The repeat application fee for NAPLEX or NAPLEX and MPJE is $100.00. The repeat application fee for only the MPJE is $25.00. Repeat application fees are payable to the Indiana Professional Licensing Agency, in accordance with 856 IAC 1-27-1.*
3. *Completed application and fees should be mailed to the address listed in the upper right hand corner of this form.*
4. *All fees are non-refundable and non-transferable.*
5. *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 FEE	
DATE FEE PAID *(month, day, year)*	
RECEIPT NUMBER	
LICENSE NUMBER	
DATE ISSUED *(month, day, year)*	

DO NOT WRITE ABOVE THIS LINE

Please indicate which test(s) you wish to take: ☐ NAPLEX ☐ MPJE ☐ Score Transfer

If you are repeating an examination, indicate the examination you will be repeating: ☐ NAPLEX ☐ MPJE

Date of last examination *(month, day, year):*	Number of times exam has been taken:

APPLICANT INFORMATION

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

e-Profile Identification number *(required: visit www.nabp.net)*	Total pharmacist intern hours	Pharmacist intern registration number	State issued	Date issued *(month, day, year)*

Name of school or college of pharmacy	Number of years attended	Date graduated *(month, day, year)*

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, disciplinary action against your license or complaints. 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, or permit that you hold or have held in any state or country? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice as a pharmacist or any regulated health occupation in any state *(including Indiana)*, country, or U.S. Territory? ☐ Yes ☐ No

3. 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

4. Have you ever been denied staff membership privileges in any pharmacy or have any privileges been revoked, suspended or subjected to any restrictions, probation or other type of discipline or limitations? ☐ Yes ☐ No

5. Have you ever had a malpractice judgment against you or settled any malpractice action? ☐ Yes ☐ No

6. 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

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 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 and the Board 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 hereby swear or affirm that I have read the above statements and agree to same.

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

ADDITIONAL INFORMATION

For more information regarding the DEA, please visit www.deadiversion.usdoj.org.

APPLICATION FOR EXAMINATION FOR A PHARMACIST'S LICENSE
CERTIFICATE OF COMPLETION

Part of State Form 36028 (12-21)
Approved by State Board of Accounts, 2017

INDIANA BOARD OF PHARMACY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

CERTIFICATE OF COMPLETION OF PHARMACY EDUCATION

☐ B.S. Pharmacy ☐ Pharm. D.

I hereby certify that _____was admitted to the degree program in the School of Pharmacy at _____on _____ and graduated with the professional degree noted above on _____.

The candidate has completed _____ years as a student in the School. There is evidence in our permanent records that the person certified here has met all the requirements of Indiana Code 25-26-13-11(a)(3) by completing the professional degree program noted here, and has completed _____ clock hours of practical experience as stated in 856 IAC 1-3.1-7 in connection with the degree program at the School _____.

Date of Certification_____ Signed_____

_____
School of Pharmacy

School Seal