Reset Form

APPLICATION FOR REPEAT EXAMINATION FOR PHARMACIST LICENSE

State Form 51636 (R6 / 9-17)
Approved by State Board of Accounts, 2017

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

INSTRUCTIONS:

1. *The fee for MPJE only is $25.00, 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. *The fee for NAPLEX or NAPLEX and MPJE is $100.00 payable to the Indiana Professional Licensing Agency, in accordance with 856 IAC 1-27-1.*
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.

APPLICATION FEE	
DATE FEE PAID (*month, day, year*)	
RECEIPT NUMBER	
LICENSE NUMBER	
DATE ISSUED (*month, day, year*)	

APPLICANT

Attach one (1) Passport type quality photograph of yourself taken within the last eight (8) weeks.

DO NOT WRITE ABOVE THIS LINE

APPLICANT INFORMATION

Name of applicant (*last, first, middle*)		Social Security number *
Date of birth (*month, day, year*)	Place of birth (*city and state or country*)	
Address of applicant (*number and street or rural route*)	City, state, and ZIP code	
Telephone number (*daytime*) ( )	E-mail address	
Gender ** ☐ Male ☐ Female	Ethnicity **	Race **

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).

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

Name of school or college of pharmacy

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

PLEASE CHECK WHICH EXAMINATION YOU WILL BE REPEATING ☐ **NAPLEX** ☐ **MPJE**

If your answer is "Yes" to any of the following, explain fully in a sworn affidavit, 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 in any state (*including Indiana*) or country? ☐ Yes ☐ No

2) Have you ever been denied a licensure, registration or certification in any state (*including Indiana*) or country? ☐ 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) Have you ever been convicted of, pled guilty or nolo contendre to any of the following:
   a. 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
   b. To any offense, misdemeanor or felony in any state? (E*xcept for minor violations of traffic laws resulting in fines?*) ☐ Yes ☐ No

5) Have you ever been denied staff membership or 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

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

7) Have you ever been treated for drug or alcohol abuse? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury, that the above statements made in this application including all attachments are true, complete and correct.

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

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 and the Indiana Board of Pharmacy any files, documents, records or other information pertaining to undersigned requested by the Agency or Board, or any of its authorized representatives in connection with processing application for licensure as a pharmacist.

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 and the Indiana Board of Pharmacy, 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*)