Reset Form

APPLICATION FOR CERTIFICATION AS A PHARMACY TECHNICIAN (CPT)

State Form 51635 (R11 / 3-25)

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
Web: www.pla.IN.gov

INSTRUCTIONS:
1. *The fee for this application 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. *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 fee	Date fee paid (*month, day, year*)	Receipt number
Certificate number issued	Permit number issued	Date issued (*month, day, year*)

DO NOT WRITE ABOVE THIS LINE

Please check all that apply:

☐ I have completed a program of education and training approved by the Board.
(*Please include verification of completion of the program and / or training.*)

☐ I have passed a certification examination offered by a nationally recognized certification body, approved by the Board.
(*Please include a copy of your certificate.*)

If you did not check at least one (1) of the above, you must apply for a Pharmacy Technician-in-Training Permit.
I am applying for a Pharmacy Technician-in-Training Permit: ☐ Yes ☐ No

If applying for a Pharmacy Technician-in-Training Permit, indicate the name and license number of the approved training program you will complete.

Name of approved training program	License number

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 **

Have you graduated from high school or do you hold a General Equivalency Diploma (GED)?
(If yes, please include a copy.) ☐ Yes ☐ No

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

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 or are formal charges pending? ☐ Yes ☐ No

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

3. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice in a competent, ethical, and professional manner? ☐ 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 contendre to any offense, misdemeanor, or felony in any state? ☐ Yes ☐ No

5. Have you ever been denied employment in a pharmacy, or had such employment revoked, suspended or subjected to any restriction, probation or other type of discipline of limitations? ☐ Yes ☐ No

6. Have you ever had a civil action filed against you for breach of your professional duties? ☐ Yes ☐ No

APPLICATION AFFIRMATION

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

Signature of applicant	Date signed (*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, or the Indiana Board of Pharmacy, any files, documents, records or other information pertaining to the undersigned requested by the Agency, or the Board, or any of their authorized representatives, in connection with processing my application for licensure.

I hereby release the aforementioned person, firm, officer, corporation, association, organization, and institution from any liability with regard to such inspection to furnishing of any such information.

I further authorize the Professional Licensing Agency, or the Indiana Board of Pharmacy, to disclose to the aforementioned person, firm, officer, corporation, association, organization, and institution any information which is material to my application, and I hereby specifically release the Agency, and the Board from any and all liability in connections 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 signed (*month, day, year*)