

## **Pharmacist License Score Transfer Application Packet**

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### **Important Social Security Number Information:**

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

### **In order to process your request:**

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
PO Box 1099  
Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Board of Pharmacy Credentialing  
PO Box 47877  
Olympia, WA 98504-7877

**Contact us:**

360.236.4700

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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

**Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.

**1. Demographic Information:**

**Social Security Number:** You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

**Legal Name:** List your full name: first, middle, and last.

**Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

**Birth date:** Provide the month, day and year of your birth.

**Birth place:** Provide the city, state and country where you were born.

**Address:** List the address we should use to send you any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).

**Phone, Fax and Cell Numbers:** Enter your phone, fax and cell numbers, if you have them.

**Email:** Enter your email address, if you have one.

**Other Name(s):** Indicate whether you are known or have been known by any other names. If you have a name change, you must notify the Department of Health in writing. You must include legal proof of this change. See [WAC 246-12-300](#).

**2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide a complete and accurate explanation. You must also submit appropriate documentation as noted in the personal data questions. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3. Other Licensure, Certification, or Registration:**

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

**4. Education and Training:**

List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

**5. Experience:**

List in date order, most recent to later, all your professional work experience since your Washington State credential was issued. Attach additional completed pages if you need more space.

**6. AIDS Education and Training Attestation:**

Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in [WAC 246-12-270](#).

**7. Applicant’s Attestation:**

You must sign and date this for us to process the application.

**8. Applicant’s Photograph:**

Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.

## **Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington**

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at [the military resources page](#) and include supporting documentation with your application.

## License Requirements

This is information to apply for a pharmacist license by score transfer. For more information visit our [Web site](#).

### General Information

1. You must be a graduate of an accredited United States pharmacy school or college.
2. Applicants taking the licensing examination in another state for the purpose of score transfer to Washington State must submit the same documentation, fees, intern hours and reports as a person taking the licensing exam in Washington State. The licensing requirements must be completed within one year from the date the board received score transfer notification from the National Association of Board of Pharmacy (NABP).
3. Washington State uses the North American Pharmacist License Exam (NAPLEX) to test your knowledge, judgment, and skills as an entry-level pharmacist. Multi state Pharmacy Jurisprudence Examination (MPJE) tests you on both federal, state laws, and rules.
4. The Pre-NAPLEX practice examination is available on the NABP Web site at [www.nabp.net](http://www.nabp.net).
5. You must submit a computerized exam registration form for both the NAPLEX and MPJE at [www.nabp.net](http://www.nabp.net) or mail it to 1600 Feehanville, MT. Prospect IL 60056. You may complete the registration forms and submit the payment by credit card, VISA or Master Card, at the NABP Web site. If you do not have a credit card and prefer not to register online, you can get the paper registration forms by sending a request with your name and address to our Customer Service Office at [hsqa.csc@doh.wa.gov](mailto:hsqa.csc@doh.wa.gov), or by calling 360.236.4700.
6. To receive your Authorization to Test (ATT):
  - Register with and pay exam fees to the NABP.
  - Submit all items required before testing to our office.

Once the above steps have been completed, WA Board of Pharmacy (BOP) will then release your name to the NABP as “ready to test”. The NABP will send your ATT.
  - We will mail the test results to you. Contact Office of Customer Service at 360.236.4700 if you have questions about licensure in Washington State.
7. Reporting intern hours: Internship hours gained in another state must be certified by the board of that state to be accepted by the Washington State Board of Pharmacy (WSBOP). In the event that a state no longer certifies intern hours, WSBOP will accept a letter from that state board acknowledging its practice not to certify hours. The letter from the state board must be accompanied by written verification of intern hours by a pharmacy school or college accredited by Accreditation Council for Pharmacy Education located in that state. A minimum of 1500 internship hours is required for licensure.

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Washington State Department of

Health

Board of Pharmacy Credentialing

PO Box 47877

Olympia, WA 98504-7877

360.236.4700

## Requirements Checklist for Score Transfer

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dates indicate when we received the following items, the absence of a date indicates that we have not received the item.

### Items required before taking MPJE:

\_\_\_\_\_ State pharmacist application with the nonrefundable fee. See online [fee page](#).

\_\_\_\_\_ Letter of recommendation.

\_\_\_\_\_ Copy of your birth certificate or passport.

\_\_\_\_\_ Proof of your graduation.

\_\_\_\_\_ Certification of 700 intern hours, we have received.

\_\_\_\_\_ Score transfer report from NABP.

### Required before pharmacist license:

\_\_\_\_\_ Preceptor Evaluation.

\_\_\_\_\_ Intern Site Evaluation Report.

\_\_\_\_\_ Certification of a total of 1500 intern hours, we have received.

\_\_\_\_\_ 7 hours of AIDS education.

\_\_\_\_\_ NAPLEX score, on \_\_\_\_\_ you received a score of \_\_\_\_\_.

\_\_\_\_\_ MPJE score, on \_\_\_\_\_ you received a score of \_\_\_\_\_.

\_\_\_\_\_ Received e-mail from NABP verifying NAPLEX and MPJE scores. This is done by Board of Pharmacy.

\_\_\_\_\_ Official transcript sent directly from your pharmacy school.

### Please send in with your application and payment.

License # \_\_\_\_\_ Issued \_\_\_\_\_ Expires \_\_\_\_\_

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Background  
Check  
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Date  
Stamp  
Here

Revenue: 0262010000

## Pharmacist License Score Transfer Application

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so may result in a delay in processing your application.

### 1. Demographic Information

**Social Security Number** (If you do not have a social security number, see instructions)

Male  
 Female

Name                      First                      Middle                      Last

Birth date (mm/dd/yyyy)

**Place of birth**

City                      State                      Country

Address

City                      State                      Zip Code                      County

Country

Phone (enter 10 digit #)

Fax (enter 10 digit #)

Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City                      State                      Zip Code                      County

Country

**Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.**

Have you ever been known under any other name(s)?  Yes  No

If yes, list name(s):

Will documents be received in another name?  Yes  No

If yes, list name(s):

**For Office Use Only**

License # \_\_\_\_\_ Date Issued \_\_\_\_\_

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction .....

**Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.**

- b. If you answered “yes” to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? .....

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
- b. Diverted controlled substances or legend drugs? .....
- c. Violated any drug law? .....
- d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....

## 3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

State/ Jurisdiction	License/Certification/Registration Type	Method Licensed			License/Certification/Registration	
		Exam	Endorse	Grandfathered	Year issued	Number

## 4. Education and Training

List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Graduate School	Degree and Major	start (mm/yyyy)	end (mm/yyyy)

## 5. Experience

List in date order, most recent to later, all your professional experience. Attach additional completed pages if you need more space.

Name and location of institution	Type of experience	start (mm/yyyy)	end (mm/yyyy)

## 6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand I should provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date
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## 7. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of Washington the following is true and correct:  
(Print applicant name clearly)

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ at \_\_\_\_\_  
(mm/dd/yyyy) (City, state)

By: \_\_\_\_\_  
(Signature of applicant)

## 8. Applicant's Photograph

**Photo Here**



Attach Current Photograph Here.  
Indicate Date Taken and Sign in  
Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

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## Letter of Recommendation

Date: \_\_\_\_\_

To Washington State Board of Pharmacy:

I hereby certify that I am a licensed pharmacist in good standing in the state of \_\_\_\_\_, my credential number is: \_\_\_\_\_. I further certify that I have been personally acquainted with \_\_\_\_\_ for \_\_\_\_\_ months and years and to the best of my knowledge, I believe he or she is of good moral and professional character. I confirm that he or she is free from habits liable to interfere with his or her professional services. He or she is worthy of receiving a license to practice pharmacy in the State of Washington.

Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Print name \_\_\_\_\_ Signature \_\_\_\_\_

Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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## Preceptor Evaluation and Certification of Experience

This form must be submitted to the board office at the completion of the internship experience. If the internship experience exceeds twelve months, it is recommended this form be filed annually.

Name of Intern		Year in school if applies <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	
Intern street address			
City		State	Zip Code
Name of preceptor			
Name of internship site			
Street address			
City		State	Zip Code

### Preceptor Evaluation of Intern

Briefly describe the type of professional experience received under your supervision. Comment on the intern's communication skills, accuracy, professional attitude, dispensing skills, ability to evaluate and monitor therapy, and knowledge of pharmacy management. Also, pursuant to [WAC 246-858-070\(3\)](#), provide your assessment of the intern's ability to practice pharmacy at this stage of his or her internship. If you need more space, attach a piece of paper.

Signature of Preceptor \_\_\_\_\_ Date \_\_\_\_\_





## **RCW/WAC and Online Web Site Links**

### **RCW/WAC Links**

Uniform Disciplinary Act.....	<a href="#">RCW 18.130</a>
Administrative Procedure Act .....	<a href="#">RCW 34.05</a>
Administrative procedures and requirements .....	<a href="#">WAC 246-12</a>
Pharmacy RCW.....	<a href="#">RCW 18.64</a>
Pharmacy WAC .....	<a href="#">WAC 246-863</a>

### **On-Line**

AIDS Training Resources .....	<a href="#">Reference Page</a>
AIDS Education and Training.....	<a href="http://www.doh.wa.gov/cfh/hiv/prevention/training/default.htm">http://www.doh.wa.gov/cfh/hiv/prevention/training/default.htm</a>
Pharmacy Board.....	<a href="#">Web Page</a>

### **Required Hours of Training**

Pharmacist.....	7 hours
Technician.....	4 hours
Assistant.....	4 hours