Washington State Department of Health

Pharmacy Intern for US Students Application Packet

Contents:

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, please read, complete, and return this **form** with your application.

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
P.O. Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Pharmacy Quality Assurance
Commission Credentialing
P.O. 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 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.

☐ **Select if the following applies:**
Spouse or Registered Domestic Partner of Military Personnel

☐ **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.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.

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.

Address: List the address we should use to send 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. To expedite notice to the applicant, we will use the email address as the primary contact source to update the applicant on the status of their application. It is important to ensure the email address is correct and current at all times.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include 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 an appropriate explanation. You must also provide the documentation listed in the note after the question. 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.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List all states where credentials are or were held. Attach additional completed pages if you need more space. You must also print the **Verification Form** and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

☐ **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 experience and practice from date of graduation from professional college. 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**. If AIDS education was included in your professional education or training, an additional course is not required.

☐ **7. Applicant’s Attestation:**
You must sign and date this for us to process the application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly. Documents to submit with your application should include the following:

- A copy of your spouse’s or registered domestic partner’s military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state’s declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

Washington State Department of Health

Pharmacy Intern Application Instructions
US Students

The following instructions will assist you in completing the application process for registration as a pharmacy intern in Washington State.

To register as an intern, you must be enrolled in a United States pharmacy school or be a graduate of a pharmacy school from a foreign university. Information and applications are also available at our **website**.

Once your application has been approved, a pharmacy intern registration is issued. The registration will expire on your next birthday. This registration is renewed annually.

Proof of enrollment must be received by the department before your intern registration can be issued. You may work as an intern once your registration is issued. Only hours accumulated after you have completed your first quarter or semester of pharmacy school will count towards the 1500 hours required.

To register as an intern, the pharmacy board office must receive:

- Completed application for pharmacy intern registration and the nonrefundable fee.
- Proof of enrollment sent directly from the pharmacy school.

If you have questions, please contact the customer service center at 360-236-4700.

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Washington State Department of Health

Requirements Checklist US Graduates

Note: Use this checklist as a tool to track information as you send items to the commission.

Name _____

Address _____

City _____ State _____ Zip Code _____

Items required before Intern Registration:

_____ State intern application with the non refundable application fee. See online **fee page**.

_____ Letter from accredited pharmacy school verifying enrollment.

Items required before taking NAPLEX and MPJE:

_____ State pharmacist application with the nonrefundable fee. See online **fee page**.

_____ Proof of your graduation.

Required before pharmacist license:

_____ Preceptor Evaluation (Washington State students only).

_____ Intern Site Evaluation Report (Washington State students only).

_____ 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 _____.

_____ Official transcript sent directly from your pharmacy school.

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Washington State Department of Health

Date Stamp Here

Revenue: 0262010000

Pharmacy Intern Registration Application

Please print clearly. Follow the instructions as provided. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

Select if the following applies: ☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10 digit number)	☐ Male ☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

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):

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.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

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

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? ☐ ☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? ☐ ☐

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	License/Certification/Registration Type	License/Certification/Registration		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grand Fathered

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.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		start (mm/yyyy)	end (mm/yyyy)

5. Experience

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

Name and Location of Institution	From (mm/yyyy)	To (mm/yyyy)	Type of Experience or Speciality

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, which included 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 that should I provide any false information, my license may be denied, or if issued, suspended or revoked.** If AIDS education was included in your professional education or training, an additional course is not required.

Applicant's Initials	Today's Date

7. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of the state of
(Print name of applicant clearly)

Washington that the following is true and correct:

- 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 have read all laws and rules related to my profession.

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 that 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 _____ By: _____
(mm/dd/yyyy) (Original signature of applicant)

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Washington State Department of Health
Pharmacy Quality Assurance Commission
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Intern Self-Evaluation

This form does not need to be sent to the pharmacy board.

Intern name		Year in school ☐ 1 ☐ 2 ☐ 3 ☐ 4
School Street Address		Phone (enter 10 digit #)
City	State	Zip Code
Summer Street Address		Phone (enter 10 digit #)
City	State	Zip Code
Emergency Contact		Phone (enter 10 digit #)

I. Internship Experience

Preceptor	Location	Dates	Total Hours

II. Background

Preferred practice setting upon graduation
Professional organization membership
Offices held
Skills and experiences hoped to be gained from this internship

III. Evaluation of Experience (Check the appropriate box; other experience may be added)				
Area of Study	None	Minimal	Moderate	Extensive
1. Dispensing				
2. Compounding				
3. OTC medication counseling				
4. OTC medication prescribing				
5. Patient interviewing				
6. Patient counseling				
7. Physician contact (personal)				
8. Physician contact (telephone)				
9. Use/preparation of patient profiles				
10. Review of patient medical charts				
11. Provision of drug information				
12. Medical/surgical devices				
13. Ordering and receipt of stock				
14. Controlled substance control				
15. IV admixture				
16. Pharmacy computer system				
17. Patient assessment				
18. Patient drug therapy monitoring				
19. Personnel management				
20. Pharmacy and medical terminology				
21. Triaging problems				
22. Pharmacy/patient record documentation				
23.				
24.				
25.				
26.				
27.				
28.				

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Intern Site Evaluation Report

Note: This form must be submitted to the Commission office upon completion of an internship experience. No internship hours will be accepted without this evaluation report pursuant to **WAC 246-858-050(1)**. If the internship experience exceeds twelve months, it is recommended that this form be submitted annually.

Name of Intern:	Credential #
Name of Preceptor:	
Preceptor Certificate Number:	
Preceptor Location Address:	
Preceptor License Number:	
Name of Internship Site:	
Intern evaluation of preceptor:	
Intern evaluation of internship program at this site:	
Signature of Intern	Date:

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Internship Site and Preceptor Notification

Note: This form must be submitted from each preceptor before you begin your internship experience.

Name of Intern _____

Street Address _____

City _____ State _____ Zip Code _____

Intern registration number _____

Date intern hours will start to accrue (mm/dd/yyy) _____

Internship Site _____

Street address _____

City _____ State _____ Zip Code _____

Name of preceptor _____

Pharmacist license number _____

_____ _____
Signature of intern Date (mm/dd/yyyy)

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Washington State Department of Health
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Olympia, WA 98504-7877
360-236-4700

Preceptor Evaluation & Certification of Experience

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

Name of Intern		
Year In School ☐ 1 ☐ 2 ☐ 3 ☐ 4	Credential #	
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. Attach additional completes pages if you need more space.

Signature of Preceptor	Date

For the Two-Week Period of			For the Two-Week Period of		
From (Sunday)	To (Saturday)	Hours	From (Sunday)	To (Saturday)	Hours
			Total internship hours _____		

Note: Internship hours will not be accepted after the signature date.

Preceptor Certification of Experience

I,_____ certify I am a pharmacist licensed in the

State of _____. The above named intern practiced pharmacy under my

supervision at _____ pharmacy, or under a special internship program. I certify the intern has completed goals set forth in the Washington State Pharmacy Quality Assurance Commission Experiential Training Manual. The hours here recorded are correct, and to the best of my knowledge, the experience gained by the intern has been related to the practice of pharmacy as required by law.

_____ _____ _____

Preceptor's signature Date License number

Washington State Department of Health

RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Pharmacy Laws, RCW 18.64

Pharmacy Rules, WAC 246-863

Pharmacist Internship Requirements, WAC 246-858

Online

AIDS Training Resources, Reference Page

Pharmacy Quality Assurance Commission, Web Page