



## **Pharmacist License by Examination Application Packet for (U.S. Graduates-Original License by Exam)**

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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, 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.

**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. 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 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 you currently hold or have held a credential. Attach additional completed pages if you need more space. All credentials must be verifiable via the internet or a verification form is required. See the attached [verification form](#).

**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. 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.

## License Requirements

This is information to apply for a pharmacist license by examination for (U.S. graduates-original license by exam). For more information visit our [website](#).

### General Information

1. You must be a graduate of an accredited United States pharmacy school or college.
2. Washington State uses the North American Pharmacist License Exam (NAPLEX) to test your knowledge, judgment and skills as an entry-level pharmacist. Multistate Pharmacy Jurisprudence Examination (MPJE) tests you on both federal, state laws and rules.
3. The Pre-NAPLEX practice examination is available on the National Association of Boards of Pharmacy (NABP) website at <https://nabp.pharmacy/>.
4. You must submit a computerized exam registration form for both the NAPLEX and MPJE at <https://nabp.pharmacy/> 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 Website. 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.
5. 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 Pharmacy Quality Assurance Commission will then release your name to the NABP as “ready to test”. The NABP will send your ATT.
  - We will notify you of your test results. Contact Office of Customer Service at 360-236-4700 if you have questions about licensure in Washington State.
6. Reporting intern hours: The commission accepts internship hours completed as part of an ACPE accredited college/school of pharmacy, when reported directly from the college/school of pharmacy or certifying state Pharmacy Quality Assurance Commission.

Washington students must earn 300 internship hours independent from the accredited college/school of pharmacy curriculum. Qualifying internship hours are earned under the personal supervision of a preceptor or licensed pharmacist, in a licensed pharmacy in the United States. The pharmacist’s license and preceptor certification (if applicable) is active and in good standing. Use the Preceptor Evaluation and Certification of Experience and Intern Site Evaluation forms to report these hours to the Washington State Pharmacy Quality Assurance Commission for each location.

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Washington State Department of

Health

Pharmacy Quality Assurance

Commission Credentialing

PO Box 47877

Olympia, WA 98504-7877

360-236-4700

## Requirements Checklist

This is information to apply for a Pharmacist License by Examination for (U.S. Graduates-Original License by Exam)

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 admittance.

### 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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Date  
Stamp  
Here

Revenue: 0262010000

## Pharmacist License Application

**Please check the appropriate box:**

- |  |  |
|--|--|
| <input type="checkbox"/> By Exam (NAPLEX) for U.S. Graduates Licensed only in FL or CA<br><input type="checkbox"/> By Exam (NAPLEX) for Foreign Graduates<br><input type="checkbox"/> By License Transfer/Reciprocity for Foreign Graduates<br><input type="checkbox"/> By Score Transfer - U.S. Graduates Licensed only in FL or CA | <input type="checkbox"/> By Exam (NAPLEX) for New Graduates<br><input type="checkbox"/> By Score Transfer for U.S. Graduates<br><input type="checkbox"/> By Score Transfer for Foreign Graduates<br><input type="checkbox"/> By License Transfer/Reciprocity for U.S. Graduates<br><input type="checkbox"/> By Exam (NAPLEX) for - Foreign Graduates Licensed FL or CA |
|--|--|

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

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)		<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Name	First	Middle	Last	
Birth date (mm/dd/yyyy)		<b>Place of birth</b>		
		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				
<b>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.</b>				
Have you ever been known under any other name(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, list name(s):				
Will documents be received in another name? <input type="checkbox"/> Yes <input type="checkbox"/> 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.**

**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/ 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. Professional 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.** If AIDS education was included in your professional education or training, an additional course is not required.

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

I, \_\_\_\_\_, declare under penalty of perjury under the laws of  
(Name of applicant)  
the state of 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 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  
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Olympia, WA 98504-7877  
360-236-4700

## 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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## 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 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Credential #	
Intern Street address		
City	State	Zip Code
Name of Preceptor		
Name of Internship Site		
Street Address		
City	State	Zip Code
<b>Preceptor Evaluation of Intern</b>		
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 <a href="#">WAC 246-858-070(3)</a> , 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





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## Out-Of-State Credential Verification

### To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been licensed, certified, or registered. Instruct them to return the form directly to the above address. Make a copy of this form if you need to send it to more than one state or jurisdiction. Agencies normally charge a fee for verification. Please check in advance to help expedite this process.

Name: Last			First			Middle		
Mailing Address								
City						State		Zip Code
Any other names used:								
License, Certification, or Registration Number						Date Issued		

Have the licensing agency return this completed form to the above address.

If you have any questions, please call 360-236-4700.

## (To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of license, certification, or registration holder:		
Authority providing verification: (state, name & title)		
Applicant licensed, certified, registered by: Written Examination	Date:	Score:
Name of examination:		
Other Examination	Date:	Score:
Name of examination:		
Is it current? Yes <input type="checkbox"/> No <input type="checkbox"/>	Expiration Date:	
Is this individual considered to be in good standing in your state? <input type="checkbox"/> Yes <input type="checkbox"/> No If "no", please attach explanation.		
Have they ever been denied? <input type="checkbox"/> Yes <input type="checkbox"/> No Suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No Revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No Surrendered? <input type="checkbox"/> Yes <input type="checkbox"/> No Reinstated? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "yes", please provide a copy of the final order or other documentation of action taken.		
If this individual has been disciplined, has he/she successfully completed all requirements and is currently in good standing? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Signature: \_\_\_\_\_

(SEAL)

Title: \_\_\_\_\_

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



## **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](#)

### **Online**

[AIDS Training Resources, Reference Page](#)

[Pharmacy Quality Assurance Commission, Web Page](#)