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NORTH CAROLINA BOARD OF PHARMACY RECIPROCITY APPLICATION

Print Form

Handwritten applications will not be accepted.

Today's Date: _____ Telephone: (H) _____

Email Address: _____ (B) _____

Last Name: _____ First: _____ Middle: _____ Social Security #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Place of Birth: _____ Sex: _____

College of Pharmacy Attended: _____ Location: _____

Academic Years Attended: _____ Date of Graduation: _____ Degree: _____

If Foreign Graduate, Date(s) FPGEE/TOEFL Taken: _____ Certificate Number: _____

State In Which Licensed by Examination: _____ License #: _____ Original Date of Lic: _____

NOTE: *Your license must be active and in good standing by examination in a state.*

Please List Any Other Professional Degrees or Licenses You Hold: _____

1) **List all states where you are licensed and your license number either by Reciprocity (R) or Examination (E).** You must list **all active and inactive states**. [Example: NC 0123 (E), NC 0123 (R)]: _____

2) Have you ever failed a state board examination? *(yes/no)* _____

If yes, indicate state(s) and date(s): _____

3) Please list below the **NAME** and **FULL ADDRESS** of all of your places of practice, along with **DATES**, during the past ten years or since registered if less than ten years. (Use back of this sheet if more space is needed.)

i. _____ _____ _____
Dates *Business Name* *Full Address*

ii. _____ _____ _____
Dates *Business Name* *Full Address*

iii. _____ _____ _____
Dates *Business Name* *Full Address*

iv. _____ _____ _____
Dates *Business Name* *Full Address*

v. _____ _____ _____
Dates *Business Name* *Full Address*

vi. _____ _____ _____
Dates *Business Name* *Full Address*

Note: Under North Carolina Law, making "false representations or with[holding] material information in connection with securing a license or permit" is grounds for "refus[ing] to grant . . . a license to practice pharmacy." N.C.G.S. § 90-85.38(a)(1). Any license or permit obtained through false representation or withholding of material information shall be void and of no effect. N.C.G.S. §90-85.38(c).

4. Do you have any physical, emotional, or other disability that would restrict your practice to any extent? *(yes/no)* _____

If yes, please explain: _____

5. Have you ever been discharged or forced to resign from any position as a pharmacist? *(yes/no)* _____

If yes, please explain: _____

6. Have you ever been charged with or convicted of a felony or charged with the violation of any law, either federal or state, governing the practice of pharmacy or the distribution of drugs? *(yes/no)* _____

If yes, explain. (Send ALL documentation pertaining to conviction/charge(s)): _____

7. Have you at any point in your licensure as a pharmacist been charged by any Board of Pharmacy or regulatory body on matters which could have produced an action on your license? *(yes/no)* _____

Any and all actions taken against your license must be disclosed regardless of when the action was taken. This includes any pending actions.

If you answered *yes* to question 7, explain. (Send ALL documentation pertaining to disciplinary action(s) taken): _____

8. Have you been in the ACTIVE practice of pharmacy (exclusive of managerial duties) continuously for the past five years (or since license if less than 5 years)? *yes/no* _____ If no, please explain: _____

The information furnished in this application is for the use of the Board of Pharmacy in the preliminary evaluation of the applicant's qualifications and does not serve as an authorization to practice pharmacy in North Carolina.

CLICK HERE TO PRINT, THEN SIGN BELOW

****IMPORTANT****

I, _____, hereby affirm that I have answered the foregoing questions, and that my answers are true and correct. I understand that any false information given by me may subject me to refusal to be licensed, disciplinary action by the North Carolina Board of Pharmacy, and/or any license obtained shall be void and of no effect.

_____

Signature

STATEMENT OF RELEASE

I, _____, with Social Security Number _____ do hereby grant permission for the North Carolina Board of Pharmacy to contact any places of employment at which I have held a position and that those places are authorized to RELEASE ANY INFORMATION requested by the North Carolina Board of Pharmacy pursuant to an application for a license by reciprocity in North Carolina.

_____ _____

Signature **Date**

REMINDERS

**** Make sure to keep all contact information current ****

**** If you are a foreign graduate, a copy of your FPGEC Certification must accompany this application ****

**** This application will expire after one year ****

SUBMISSION

Complete and sign credit card authorization on the next page. Mail completed application and credit card authorization to:

North Carolina Board of Pharmacy
ATTN: MISSY BETZ
6015 Farrington Rd.
Suite 201
Chapel Hill, NC 27517

North Carolina Board of Pharmacy

Print Form

6015 Farrington Road, Suite 201
Chapel Hill, North Carolina 27517
Phone: (919) 246-1050
Fax: (919) 246-1056
www.ncbop.org

AUTHORIZATION FOR CREDIT CARD CHARGE

THE NC BOARD OF PHARMACY ONLY ACCEPTS PAYMENT VIA VISA, MASTERCARD, DISCOVER, OR AMERICAN EXPRESS. NO CHECKS OR CASH ACCEPTED.

RECIPROCITY FEE IS $600.00.
YOUR CREDIT CARD WILL BE CHARGED WHEN THIS FORM IS RECEIVED IN THE BOARD OFFICE.
ALL FEES ARE NON-REFUNDABLE.

☐ VISA ☐ MasterCard ☐ DISCOVER

CREDIT CARD NUMBER *(VISA, MC, or DISCOVER)*: _____ _____ _____ _____

☐ AMERICAN EXPRESS

CREDIT CARD NUMBER *(AMERICAN EXPRESS)*: _____ _____ _____

EXPIRATION DATE *(mm / yyyy)*: _____ / _____

NAME *(exactly as it appears on the credit card)*: _____

BILLING ADDRESS: _____

ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER *(will only be used in case of card processing problems)*: _____

EMAIL ADDRESS: _____

SIGNATURE: _____

THIS FORM WILL BE DESTROYED IMMEDIATELY FOLLOWING PROCESSING OF PAYMENT.