Virginia Department of Health Professions
Board of Pharmacy

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APPLICATION FOR REGISTRATION AS A LIMITED-USE PHARMACY TECHNICIAN

For use exclusively in a free clinic

INSTRUCTIONS

1. Applicants must complete all sections.
2. Completed application must be mailed to the above address along with free clinic affidavit.

I. GENERAL INFORMATION

Name: Last	First			Middle/Maiden
Street Address (official address of record**)	City	State	Zip Code	Telephone Number
Street Address (public address of record)	City	State	Zip Code	Telephone Number
Date of Birth	**Social Security Number or Virginia DMV Control Number**			
Email Address	NABP E-Profile ID Number			
Do you currently or have you previously had a Pharmacy Technician Trainee Registration with the Virginia Board of Pharmacy?	YES ☐ Registration # _____			NO ☐

**In accordance with § 54.1-2400.02 of the Code of Virginia, an applicant must provide an official address of record. An applicant may choose to provide a second address for public dissemination, which may be a work address, a post office box, or a home address. If an applicant does not provide a second address, his official address of record shall also be used as the public address for the purpose of public dissemination.

II. NATIONAL EXAM CERTIFICATION

National Certification from National Healthcareer Association (NHA), or Pharmacy Technician Certification Board (PTCB)	YES ☐ National Certification Number: _____ Exp Date: _____	NO ☐

For Finance and Board use only			**0231**
Date:	**Applicant Number:**		
Date issued:		**Reviewed by and date:**	**Scanned by:**

III. TRAINING PROGRAM INFORMATION		
Completion of Board-Approved Pharmacy Technician Training Program **OR**	YES ☐	NO ☐
Completion of jointly accredited ASHP/ACPE Pharmacy Technician Training Program **OR**	YES ☐ **A copy of the certificate of completion from the training program must accompany this application.**	NO ☐
Completion of a Pharmacy Technician Training Program recognized by PTCB or NHA **OR**	YES ☐ **A copy of the certificate of completion from the training program must accompany this application.**	NO ☐
Completion of Accredited Pharmacy Technician Training Program operated through the Department of Education's Career and Technical Education Program **OR**	YES ☐ **A copy of the certificate of completion from the training program must accompany this application.**	NO ☐
Completion of Pharmacy Technician Training Program operated through a federal agency or branch of the military **OR**	YES ☐ **A copy of the certificate of completion from the training program must accompany this application.**	NO ☐
Completed or was enrolled in a Board-approved Pharmacy Technician Training Program prior to 7/1/2022 but did not pass exam until after 7/1/2022. **OR**	YES ☐ **Enter the name of training program below.**	NO ☐
Passed a National exam prior to 7/1/2022, but did not complete a Board-approved Pharmacy Technician Training Program prior to 7/1/2022 **OR**	YES ☐ **Enter the name of training program below.**	NO ☐
I have practiced as a pharmacy technician in another state	State: _____ License # _____ Dates of Practice:	

IV. ADDITIONAL LICENSURE, CERTIFICATION, OR REGISTRATION: List all states or other jurisdictions in which you have ever held a license, certification or registration as a pharmacy technician (use extra paper if necessary).

STATE	NUMBER	EXPIRATION DATE

APPLICATION QUESTIONS – NOTE: Attach additional pages if needed as well as any related documents requested. If your response to any of the questions below requires you to submit additional documentation, please provide a personal statement explaining the circumstances regarding each response to assist the Board with processing your application.

		YES	NO
1.	Have you ever been denied a pharmacy technician license, certification, or registration? **If yes, state where, explain the reason, and attach any related document**s:	☐	☐
2.	Have you ever had disciplinary action against your pharmacy technician license, certification, or registration in any other jurisdiction, or have been prohibited from performing the duties of a pharmacy technician by any other state, or prohibited by a health regulatory board of any state or by any federal agency from practicing, or assisting in the practice of, any health profession? **If yes, what jurisdiction and date, explain, and attach any official documents related to your case.**	☐	☐
3.	Have you ever been convicted of a violation of local, state or federal statute, regulation or ordinance, or entered into any plea agreement relating to a felony or misdemeanor? (Exclude traffic violations, except convictions for driving under the influence and reckless driving). **If yes, what jurisdiction and date where charged or convicted, explain, and attach copies of any official documents such as warrants and court orders showing the nature and disposition of such charges or convictions. Additionally, any information concerning an arrest, charge, or conviction that has been sealed, including arrests, charges, or convictions for possession of marijuana, does not have to be disclosed.**	☐	☐
4.	Within the past five years, have you exhibited any conduct or behavior that could call into question your ability to practice in a competent and professional manner? **If yes, provide full explanation including if you have been directed to seek treatment for your conduct or behavior.**	☐	☐
5.	Within the past five years, have you been disciplined by any entity? **If yes, please provide a full explanation and any associated orders or letters from entity.**	☐	☐
6.	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients or clients? **If yes, please provide a full explanation. Note: The Board may ask for additional documentation.**	☐	☐
7.	Are you able to perform the essential functions in your area of practice with or without reasonable accommodation? **If no, please provide a full explanation. Note: The Board may ask for additional documentation.**	☐	☐
8.	Within the past five years, have any conditions or restrictions been imposed upon you or your practice to avoid disciplinary action by any entity? **If yes, please provide a full explanation and any associated orders or letters from the entity. NOTE: The Board may request a copy of a current participation contract and summary of compliance and/or documentation of successful completion. You may consider requesting your provider send this documentation directly to the Board.**	☐	☐
9.	Are you a spouse of someone who is on federal active duty orders pursuant to Title 10 of the U. S. Code or of a veteran who has left active-duty service within one year of submission of this application and who is accompanying your spouse to Virginia or an adjoining state or the District of Columbia?	☐	☐
10.	Are you active duty military?	☐	☐

VI. APPLICANT'S STATEMENT (The following statement must be signed)

I, _____ hereby certify and affirm that the statements contained
(Print Name)

in this application for registration as a limited-use pharmacy technician in the Commonwealth of Virginia are true and accurate in every respect. I hereby make application for registration as a **Limited-Use Pharmacy Technician** in the Commonwealth of Virginia. The following evidence of my qualifications is submitted. I understand that I may not work as a pharmacy technician in a pharmacy other than a free clinic pharmacy with this limited registration.

Signature of applicant Date

VII. FREE CLINIC AFFIDAVIT FOR LIMITED-USE PHARMACY TECHNICIAN

To be completed by free clinic director or pharmacist-in-charge

I certify that the above named applicant for a limited-use pharmacy permit is currently working or planning to work, or currently volunteering or planning to volunteer as a pharmacy technician in the free clinic also noted above, and to the best of my knowledge, is not performing pharmacy technician duties in a setting other than a free clinic.

_____
Name of free clinic

_____ _____ _____
Signature of PIC or director **Print name legibly** **Date**