



Virginia Department of
Health Professions
Board of Pharmacy

9960 Mayland Drive, Suite 300

Henrico, Virginia 23233

(804) 367-4456 (Tel)

(804) 527-4472 (Fax)

pharmbd@dhp.virginia.gov

www.dhp.virginia.gov/pharmacy

Application for Registration as a Pharmacy Intern

Application Fee: \$20.00

The required non-refundable fee must accompany the application. Make check payable to "Treasurer of Virginia".

Applicant - Please provide the information requested below. (Print or Type)

Name: Last		First		Middle/Maiden		
Street Address (official address of record**)			City	State	Zip Code	Tel Number
Street Address			City	State	Zip Code	Tel Number
Date of Birth			Social Security Number or Virginia DMV Control Number			
Email Address			NABP E-Profile ID Number			
Name and address of College of Pharmacy			Enrollment Date		Graduation Date or Expected Graduation Date	

**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.

ANSWER THE FOLLOWING QUESTIONS: Attach additional page if needed as well as any related documents

	YES	NO
1. 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. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
2. 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. _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
<p>3. 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.</p> <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>4. Do you currently have any physical condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? “Currently means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Intern. If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board.</p> <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>5. Do you currently have any mental health condition or impairment that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Intern. If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board.</p> <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>6. Do you currently have any condition or impairment related to alcohol or other substance use that affects or limits your ability to perform any of the obligations and responsibilities of professional practice in a safe and competent manner? “Currently” means recently enough so that the condition could reasonably have an impact on your ability to function as a practicing Pharmacy Intern? If yes, please provide a full explanation. NOTE: The Board may request a letter from your current treatment provider addressing your current condition and ability to safely practice. You may consider requesting your provider send this documentation directly to the Board</p> <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>7. 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.</p> <hr/> <hr/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>8. 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?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>9. Are you active duty military?</p>	<input type="checkbox"/>	<input type="checkbox"/>

COLLEGE AFFIDAVIT - * Please disregard if a college affidavit was previously submitted to the Board within the past two years.**

SECTION I (students currently enrolled)

I hereby certify that the above-referenced applicant is currently enrolled at the _____
(College of Pharmacy)

Expected Date of Graduation: _____

SECTION II (students that have graduated)

I hereby certify that the above-referenced applicant has graduated from the _____
(College of Pharmacy)

Total years completed _____

Date Graduation was conferred: _____

Total Number of Practical Experience Hours Obtained: _____
(Total contains both IPPE and APPE hours)

SECTION III – College Seal

SEAL

SECTION IV - Signature

Signature of the Dean or Registrar

Date

VIII. AFFIDAVIT OF APPLICANT (The following statement must be signed)

I _____ hereby certify and affirm that the statements contained in this application for
(print name)
Registration as a pharmacy intern in the Commonwealth of Virginia are true and accurate in every respect.

Signature

Date