



STATE OF MAINE BOARD OF PHARMACY

**Application and applicant information to assist
in completing your application**

Student Pharmacist Advanced Pharmacy Practice Experience ("APPE")

(this application applies if you are completing the 1500 hours
Advanced training through the college you are enrolled at)

**Do not return the following informational pages with your
application; it is for your information only**

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation

(Mailing address) 35 State House Station, Augusta, ME 04333

(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

**Note: The office location address may be used only for overnight deliveries only. The
office address does not accept postal deliveries. You must use the mailing address for all
other regular mail deliveries.**

Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603

TTY/Hearing Impaired 1-888-577-6690

FAX (207) 624-8637

Web address: www.maine.gov/professionallicensing

Email: pharmacy.lic@maine.gov

APPLICATION INSTRUCTIONS **STUDENT PHARMACIST/APPE**

****Fax submissions of applications and supporting documentation will not be accepted.**

Board and Related Laws and Rules. Laws and rules are available online at our website. Following is a suggested list of laws and regulations for you to read and become familiar with. This list may be inclusive, for more detailed information visit our website at www.maine.gov/professionallicensing.

- Maine Pharmacy law 32MRS, Chapter 117
- Maine Board of Pharmacy rules 02 392 Chapters 1-32
- Maine Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation law 10 MRS §8001-8003 et al.
- Maine Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation rules 02 041 Chapters 10, 11, and 13

INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED. Be sure to initial the bottom of each page where noted on your application. This is critical to insuring that each page of your application is intact with the correlating application and will help us with expediting your application review. All pages requiring initials must be returned to our office as part of your complete application.

The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if supporting documents and/or fees are omitted.** Documents that have been modified or altered (including the use of any white out substance) in any way will not be accepted.

PROCESSING TIME:

✓ Please do not call our office regarding the status of your application as numerous calls will delay the timeliness of processing applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are printed off site and require at least 14 business days for delivery.

VERIFICATION OF LICENSURE IN ANOTHER STATE OR JURISDICTION

If you hold or have held a professional license in another state or jurisdiction, you must submit evidence from the State or Jurisdiction of licensure in the form of a License Verification.

Please contact the State or Jurisdiction of licensure to request an official License Verification. At a minimum, the license verification must contain:

- Name of State or Jurisdiction providing the License Verification
- Your name
- License number and expiration date
- Status of your license i.e. active, inactive, lapsed, probation, restricted, suspended, revoked...
- Type of license issued to you
- Date your license was issued
- If appropriate, hours of internship completed with beginning and ending dates
- Method your license was issued i.e. Original State, Reciprocity/Endorsement, Score Transfer
- Examinations taken
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing State or Jurisdiction providing License Verification
- State Seal

Please direct the licensing State or Jurisdiction to send the License Verification report to you directly and in turn you must submit this verification with your completed Maine application.

A sample license verification form is available on the Board's website in the application and forms section.

IMPORTANT: Applications submitted without all of the Verifications of Licensure from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

You may also obtain an electronically produced License Verification directly from the State Board website. For electronic License Verifications please be sure that it contains the State web-address and date the License Verification was printed.

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 Hearing Impaired: (888) 577-6690 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) or credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.



**STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
INDIVIDUAL LICENSE APPLICATION**

APPLICANT INFORMATION (please print)

FULL LEGAL NAME	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
ANY OTHER NAMES EVER USED:			
DATE OF BIRTH	<i>mm / dd / yyyy</i>	SOCIAL SECURITY NUMBER	- -
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ()	FAX # ()	E-MAIL	

CRIMINAL BACKGROUND DISCLOSURE

NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.

- 1. Have you ever been convicted by any court of any crime?**
(circle one) **NO** **YES**
 If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.
- 2. Has any jurisdiction (including Maine) taken disciplinary action against any professional license you hold or have held, or denied your application for licensure?** (circle one) **NO** **YES**
 If yes, enclose a detailed explanation and copies of all documents.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE	DATE
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Board of Pharmacy
Student Pharmacist
Advanced Pharmacy Practice Experience (“APPE”)
Required Fees: \$46.00
 (includes license and criminal record check fees)

Office Use Only:
PTI 1421 - \$25.00
2619 - \$21.00

Office Use Only:

Check # _____
 Amount: _____
 Cash # _____
 Lic. # _____

PAYMENT OPTIONS:

Make checks payable to “Maine State Treasurer” - If you wish to pay by Mastercard or Visa, fill out the following:

NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD the following amount: \$ _____			
Card number:	<i>XXXX-XXXX-XXXX-XXXX</i>	Expiration Date	<i>mm / yyyy</i>

SIGNATURE	DATE
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SECTION 1: Do you currently or have you ever held a Pharmacy Technician license in Maine or any other state? Yes No

If you answered yes to the question above, fill out the section below.

LIST BELOW EVERY STATE OR JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PROFESSIONAL TECHNICIAN LICENSE. Including pharmacy technician advanced, pharmacy intern or any other professional license.

1. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
4. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
5. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date

Use a separate sheet of paper if additional space is needed.

SECTION 2: Information relevant for student applying for a Pharmacy Technician APPE License.

Education for the APPE training.

Name of College in which you are currently enrolled in a pharmaceutical program.		
Address		
City	State	Zip Code
Telephone Number		
()		
Date of Enrollment	Number of years of Pharmacy Program Completed	

INITIALS OF APPLICANT

SECTION 3: Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

<p>Have you ever received a sanction from Medicare or from a state Medicaid program?</p> <p>1. <input type="checkbox"/> Medicare <u>OR</u> <input type="checkbox"/> Medicaid Program (State) _____</p> <p>2. Submit a copy of the official action by the entity.</p> <p>3. Provide a detailed explanation in your own words on a separate sheet of paper.</p> <p>Clarification on programs:</p> <ul style="list-style-type: none"> • Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease. • Medicaid – Health program administered by the United States government for people with limited incomes. • MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid. 	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
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SECTION 4: NOTICES

Public Information

This application is a public record for purposes of Maine’s Freedom of Access Law, 1 MRS §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State’s website.

10 Day Notification Requirement

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

- a. Change of name or address of the licensee;
- b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;
- c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or
- d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

_____ INITIALS OF APPLICANT

SECTION 4 (CONTINUED): NOTICES

Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRS section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

SECTION 5: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

The Applicant certifies by his/her signature that the management of the pharmacy will be vested with the licensed pharmacist in all matters directly or indirectly related to the practice of pharmacy or in any matters related to health, welfare, and safety of the public, as required by 32 MRS Section 13752(4).

Applications that are incomplete, altered (including the use of any white out substance), defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing sup-

Printed Name of Applicant	Title
Signature of Applicant	Date

porting documents, and/or missing or wrong fee.

Before mailing, double check that you have done the following:

- √ **Application is complete to include all signatures and initials are present**
- √ **Verification of licenses are attached for all states/jurisdictions held (if applicable)**
- √ **Completed Statement of College**
- √ **Completed Statement of Preceptor (if applicable)**
- √ **Your written statement (which should include your signature) of each criminal conviction(s) reported AND the supporting court records for each of the conviction(s) are attached (if applicable)**
- √ **Copy of any disciplinary action(s) taken by another state or jurisdiction (if applicable)**



State of Maine

BOARD OF PHARMACY

Statement of College

(For completion by College of Pharmacy Official)

(Required to be completed only if Section 2 of application has been completed)

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation

(Mailing address) 35 State House Station, Augusta, ME 04333

(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

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SECTION 1: STUDENT PHARMACIST INFORMATION

Name of Student
Name of College where student is currently enrolled
Name of person completing this form

SECTION 2: PRACTICE SITE

Please list all pharmacy locations where the student will be completing the APPE:

1. Name of Pharmacy		Pharmacy Lic#	
Pharmacy Address	City	State	Zip
Pharmacist in Charge		Pharmacist Lic. No.	
2. Name of Pharmacy		Pharmacy Lic#	
Pharmacy Address	City	State	Zip
Pharmacist in Charge		Pharmacist Lic. No.	

Use a separate sheet of paper if additional space is needed.

_____ INITIALS OF COLLEGE OFFICIAL

SECTION 3: Written Affiliation Agreement

College of Pharmacy must have the written affiliation agreement between the college and practice site named in Section 2 above. If a written affiliation agreement is not on file with this office, this application will be returned.

If one is on file with this office, check here **OR** attach copy of agreement and check here.

1. Name of Preceptor		Maine License Number	Expiration Date
Name of Pharmacy	Address		Pharmacy Lic. No.

2. Name of Preceptor		Maine License Number	Expiration Date
Name of Pharmacy	Address		Pharmacy Lic. No.

_____ INITIALS OF COLLEGE OFFICIAL

Office Use Only:
<input type="checkbox"/> Agreement on file
<input type="checkbox"/> Agreement attached
Verified by: _____



State of Maine

BOARD OF PHARMACY

Statement of Preceptor

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation

(Mailing address) 35 State House Station, Augusta, ME 04333

(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

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Email: pharmacy.lic@maine.gov

STATEMENT OF PRECEPTOR

Fill out the section below if applicant is seeking Intern hours:

Intern - Last Name	First Name	Middle Name
Contact Address		
Street or P.O. Box		
City	State	Zip Code
Maine Pharmacy Technician Intern License Number, required to obtain internship credit hours.		Expiration Date

SECTION 2 Complete this section if Training Site is a Pharmacy Board Licensed Facility
 If the training site is owned by an individual other than the preceptor, has the owner or employer approved the training of interns? Yes No

Type of Site, please check all that apply:		
<input type="checkbox"/> Retail Chain <input type="checkbox"/> Retail Independent <input type="checkbox"/> Nuclear Pharmacy <input type="checkbox"/> Long Term Care Pharmacy <input type="checkbox"/> Opiate Treatment Program/Center	<input type="checkbox"/> Drug Outlet in a Hospital <input type="checkbox"/> Automated Dispensing <input type="checkbox"/> Central Fill Pharmacy <input type="checkbox"/> Central Fill Processing	
Name of Facility		License Number
Physical Address		
City	State	Zip Code
Telephone Number		
()		

SECTION 3 Complete this section if Training Site is a Non Traditional Practice Setting
 If the training site is owned by an individual other than the preceptor, has the owner or employer approved the training of interns? Yes No

Non traditional practice setting (requires formal request and approval of the Board):	
<input type="checkbox"/> Manufacturer <input type="checkbox"/> Wholesaler <input type="checkbox"/> Research <input type="checkbox"/> Consulting	<input type="checkbox"/> Drug Utilization Review <input type="checkbox"/> Physician's Office <input type="checkbox"/> Industry Sponsored Programs <input type="checkbox"/> Other (specify): _____

_____ INITIAL THIS PAGE

SECTION 3: Con't

Name of Facility		License Number, if applicable
Physical Address		
City	State	Zip Code
Telephone Number		
()		
Name of Person Supervising Intern		Title

SECTION 4: PRECEPTOR

Name of Preceptor Pharmacist	License Number	Title
<p>I certify that I am a licensed pharmacist holding a current active license and have been engaged in the practice of pharmacy for at least two (2) years on a full-time basis immediately prior to serving as preceptor. I hereby agree to serve as preceptor for the intern named above who holds a current Maine Pharmacy Technician Intern license. I understand that as this intern's preceptor I am responsible for providing appropriate supervision to this intern while he/she is practicing pharmacy and for all aspects of the internship program. I further understand that I shall be responsible for certifying the intern's practical experience and for completing the appropriate affidavit required by the Board of Pharmacy and for submitting reports on the progress and aptitude of the intern upon request. By submitting this application I understand that the Board of Pharmacy will rely upon this information and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.</p>		
Signature of Preceptor		Date

Approved Preceptors can be viewed under the licensee profile when doing an online licensee search.

FOR BOARD USE ONLY		
Preceptor Statement:	Accepted	Not Accepted
Action Date: _____		
Reason for non-approval: _____		

By: _____		