Pharmacist Licensure by Endorsement Application for Non-U.S. Graduates

Board of Pharmacy
P.O. Box 6330
Tallahassee, FL 32314-6330
Website: www.floridaspharmacy.gov
Email: info@floridaspharmacy.gov
Phone: (850) 245-4474
FAX: (850) 921-5389

Florida HEALTH
Medical Quality Assurance

Are you an active duty member of the United States Armed Services?

Are you a veteran of the United States Armed Services?

Are you the spouse of a veteran of the United States Armed Services?

Are you the spouse of an active member of the United States Armed Services?

If you answered “Yes” to any of these questions, you may qualify for a reduction in your application fees. You can find information about the Florida Department of Health’s commitment to serving members and veterans of the United States Armed Forces and their families online at

http://www.flhealthsource.gov/valor

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Do Not Write in this Space
For Revenue Receipting Only

If you were **educated in the United States**, download the Pharmacist Endorsement Application for U.S. Graduates.

Pharmacist (1015) **$295.00**

Total fee of $295.00 includes the following:	
Application Fee	$100.00
Initial Licensure Fee	$190.00
Unlicensed Activity Fee	$5.00

Fees must be paid in the form of a cashier's check or money order, made payable to the Department of Health. An applicant who is denied licensure or withdraws their application is entitled to a $195.00 (Licensure Fee and Unlicensed Activity Fee) refund. Requests to withdraw or for a refund must be made in writing. Fees are refundable for up to three years from the date of receipt.

1. PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____
Last/Surname First Middle MM/DD/YYYY

Mailing Address: (The address where mail and your license should be sent)

_____ _____ _____
Street/P.O. Box Apt. No. City

_____ _____ _____ _____
State ZIP Country Home/Cell Telephone (Input without dashes)

Physical Location: (Required if mailing address is a P.O. Box- This address will be posted on the Department of Health's website) (If you ae not employed, please list your mailing address below. If you have multiple practice locations, submit on an additional sheet).

_____ _____ _____
Street (Place of Employment) Apt. No. City

_____ _____ _____ _____
State ZIP Country Work/Cell Telephone (Input without dashes)

EQUAL OPPORTUNITY DATA:

We are required to ask that you furnish the following information as part of your voluntary compliance with 41 CFR Part 60-3-Uniform Guidelines on Employee Selection Procedure (1978); 43 FR 38295 and 38296 (August 25, 1978). This information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure.

Gender: ☐ Male ☐ Female

Race: ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Two or More Races ☐ Hispanic or Latino ☐ Black or African American ☐ White ☐ Asian

Email Notification: To be notified of the status of your application by email, check the "Yes" box and fill in your email address on the line provided. If you choose to be notified via email you will be responsible for checking your email regularly and updating your email address with the board office.

☐ Yes ☐ No Email Address: _____

Under Florida law, email addresses are public records. If you do not want your email address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

2. SOCIAL SECURITY DISCLOSURE

This information is exempt from public records disclosure.

Last Name: _____

First Name: _____

Middle Name: _____

Social Security Number: _____
(Input without dashes)

Pursuant to Title 42 United States Code, § 666(a)(13), the Department of Health is required and authorized to collect Social Security numbers relating to applications for professional licensure. For all professions regulated under chapter (ch.) 456, Florida Statutes (F.S.), the collection of Social Security numbers is required by section (s.) 456.013(1)(a), F.S.

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Name: _____

3. METHOD OF APPLICATION

Select **ONE** of the methods of application listed below:

☐ **A.** Two years of active practice within two of the last five years.
☐ **B.** Successful completion of a board-approved post-graduate training course.
☐ **C.** Successful completion of a board-approved post-graduate clinical competency examination.
☐ **D.** Successful completion of a 2,080-hour internship within the immediately preceding two years.

☐ **You must submit proof** that the requirement you selected has been met. Non-U.S. Graduates must also meet the requirements of s. 465.007(1)(b)(2), F.S. If you do not meet any of the methods listed above, you must apply by examination.

If you selected **option A**, you must also demonstrate that you have completed 30 hours of continuing education in the previous two calendar years.

If you selected **option D**, your internship date will be determined by the board based on your graduation date, unless the state board of pharmacy where your hours were earned submits the certification of 2,080 intern hours earned in that state within the preceding two years.

4. APPLICANT BACKGROUND

A. Have you ever changed your name through marriage or through action of a court or have you ever been known by any other name? ☐ Yes ☐ No

If "Yes," list name(s) and date(s) of the change(s) below. Attach additional sheets if necessary.

_____

B. Do you hold, or have you ever held a license to practice as a pharmacist or any other pharmacy related license(s)? ☐ Yes ☐ No

C. List all pharmacy related licenses (active, inactive or lapsed).

License Type	License #	State/Country	Original Date Issued (MM/DD/YYYY)	Expiration Date (MM/DD/YYYY)	Status of License

☐ **Submit a License Verification** form to **ALL** state(s) of licensure. License verifications must be received directly from the licensing authority regardless of the status of the license. Online verifications submitted by the applicant are acceptable if they are current and show disciplinary history status.

D. If you are applying **under method 3A**, list two years of work experience. You are required to submit one Internship or Work Experience form (Form B) for each employer listed below.

If you are applying **under methods 3B, 3C, or 3D** list internship experience.

Employer	Location Address	Intern or Pharmacy Experience?	Dates: From-To (MM/DD/YYYY)	Total Hours
			to	
			to	
			to	

Name: _____

5. DISASTER

Would you be willing to provide health services in special needs shelters or to help staff disaster medical assistance teams during times of emergency or major disaster? ☐ Yes ☐ No

6. EDUCATION HISTORY

List the name of university, college, or school of pharmacy you attended.

School Name	City/State or Country	Graduation Date (MM/DD/YYYY)	Degree Awarded

☐ All applicants must document completion of the 500 hours in Florida. The 500 hours completed in Florida must be documented on the **"Work Statement of Completed Hours"** form found at the end of this application. The work experience program, including both the preceptor and the permittee, must be approved by the Board of Pharmacy.

Name: _____

7. EXAM INFORMATION

You must have passing scores on the North American Pharmacist Licensure Examination (NAPLEX®) and the Multistate Pharmacy Jurisprudence Examination (MPJE®) (also referred to as the "Florida law examination"). Both parts of the examination are computerized and can be taken in your state. Exams are offered every day of the year with the exception of holidays and Sundays. Please refer to the NAPLEX®/MPJE® Registration Bulletin for testing locations in your state. The Registration Bulletin is available at https://nabp.pharmacy/programs/examinations/.

The board is a participant in the NAPLEX® Score Transfer Program. Review requirements for the NAPLEX® Score Transfer Program in the NAPLEX®/MPJE® Registration Bulletin.

A. Indicate the date you successfully completed the NAPLEX® examination. Date: _____ MM/DD/YYYY

B. Complete the appropriate section(s).

Test of English as a Foreign Language (TOEFL)- must have scored a minimum of 213 on the computer-based test or a minimum of a 550 on the paper and pencil test to meet requirements. **Date passed:** _____ MM/DD/YYYY **Score:** _____	**OR**	**TOEFL iBT**- must have scored a minimum of the following scores in each category to meet requirements: 18 in Listening, 21 in Reading, 26 in Speaking, and a 24 in Writing. **Date passed:** _____ MM/DD/YYYY **Score:** _____
AND		
Test of Spoken English (TSE)- must have scored a minimum of a 50 to meet requirements. **Date passed:** _____ MM/DD/YYYY **Score:** _____		

C. You must have obtained a passing score on the **Foreign Pharmacy Graduate Equivalency Examination (FPGEE).** For further information visit https://nabp.pharmacy/programs/fpgee/.

Date taken and passed: _____ MM/DD/YYYY Score: _____

D. **Special Testing Accommodations-** Please indicate if you require special testing accommodations. All testing accommodation requests submitted by candidates will be evaluated by the National Association of Boards of Pharmacy (NABP). For more information regarding testing accommodations please review the NAPLEX®/MPJE® Registration Bulletin. ☐ Yes ☐ No

This information is exempt from public records disclosure.

8. HEALTH HISTORY

The board and the department, as part of its responsibility to protect the health, safety, and welfare of the public, must assess whether an applicant manifests any physical, mental health, or substance use issue that impairs the applicant's ability to meet the eligibility requirements for a health care practitioner as defined in ch. 456, F.S., and the applicable statutory practice acts.

The board and the department support applicants seeking treatment and views effective treatment by a licensed professional as enhancing the applicant's ability to meet the eligibility requirements to practice a health care profession.

Seeking assistance with stress, mild anxiety, situational depression, family or marital issues will not adversely affect the outcome of a Florida health care practitioner application. The board and the department do not request that applicants disclose such assistance.

1. During the last two years, have you been treated for or had a recurrence of a diagnosed physical or mental disorder that impaired or impairs your ability to practice? ☐ Yes ☐ No
2. During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol or drug) disorder that impaired or impairs your ability to practice? ☐ Yes ☐ No

If a "Yes" response was provided to any of the questions in this section, provide the following documents directly to the board office:

☐ **A letter from a licensed health care practitioner**, who is qualified by skill and training to address the condition identified, which explains the impact the condition may have on the ability to practice the profession with reasonable skill and safety. The letter must specify that the applicant is safe to practice the profession without restrictions or specifically indicate the restrictions that are necessary. Documentation provided must be dated within one year of the application date.

☐ **A written self-explanation**, identifying the medical condition(s) or occurrence(s); and current status.

Name: _____

9. DISCIPLINE HISTORY

A. Has disciplinary action ever been taken against your pharmacist license, or any other professional license you may have in this state or any other state? ☐ Yes ☐ No

B. Have you ever surrendered your pharmacist or any other professional license in another jurisdiction when disciplinary action was pending? ☐ Yes ☐ No

C. Are you presently being investigated or is any disciplinary action pending against you? ☐ Yes ☐ No

If you respond "Yes" to any of the questions in this section, complete the following:

Name of Agency	State	Action Date (MM/DD/YYYY)	Final Action	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding the disciplinary action.

☐ A copy of the **Administrative Complaint** and **Final Order**.

10. CRIMINAL HISTORY

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to any crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld. Pursuant to s. 943.0585(6)(b), F.S., and s. 943.059(6)(b), F.S., an applicant seeking to be licensed by the Department of Health must disclose expunged and sealed criminal history records.

Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question. ☐ Yes ☐ No

If you responded "Yes" in this section, complete the following:

Offense	Jurisdiction	Date (MM/DD/YYYY)	Final Disposition	Under Appeal?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

If you responded "Yes," you must provide the following:

☐ **A written self-explanation**, describing in detail the circumstances surrounding each offense; including date, city and state, charges and final results.

☐ **Final Dispositions** and **Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. Unavailability of these documents must come in the form of a letter from the Clerk of the Court.

☐ **Completion of Sentence Documents**. You may obtain documents from the Department of Corrections. The report must include the start date, end date, and that the conditions were met.

Name: _____

11. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

IMPORTANT NOTICE: Applicants for licensure, certification, or registration and candidates for examination may be excluded from licensure, certification, or registration if their felony convictions fall into certain timeframes as established in s. 456.0635(2), F.S.

1. Have you been convicted of, or entered a plea of guilty or nolo contendere, regardless of adjudication, to a felony under ch. 409, F.S. (relating to social and economic assistance), ch. 817, F.S. (relating to fraudulent practices), ch. 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 2.

   a. If "Yes" to 1, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   b. If "Yes" to 1, for the felonies of the third degree, has it been more than ten years from the date of the plea, sentence, and completion of subsequent probation (this question does not apply to felonies of the third degree under s. 893.13(6)(a), F.S.)? ☐ Yes ☐ No

   c. If "Yes" to 1, for the felonies of the third degree under s. 893.13(6)(a), F.S., has it been more than five years from the date of the plea, sentence, and completion of any subsequent probation? ☐ Yes ☐ No

   d. If "Yes" to 1, have you successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed (if "Yes," provide supporting documentation)? ☐ Yes ☐ No

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, to a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 3.

   a. If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended? ☐ Yes ☐ No

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to s. 409.913, F.S.? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 4.

   a. If you have been terminated but reinstated, have you been in good standing with the Florida Medicaid Program for the most recent five years? ☐ Yes ☐ No

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? ☐ Yes ☐ No

If you responded "No" to the question above, skip to question 5.

   a. Have you been in good standing with a state Medicaid program for the most recent five years? ☐ Yes ☐ No

   b. Did termination occur at least 20 years before the date of this application? ☐ Yes ☐ No

Name: _____

5. Are you currently listed on the United States Department of Health and Human Services' Office of the Inspector General's List of Excluded Individuals and Entities (LEIE)? ☐ Yes ☐ No

   a. If you responded "Yes" to the question above, are you listed because you defaulted or are delinquent on a student loan? ☐ Yes ☐ No

   b. If you respond "Yes" to question 5.a., is the student loan default or delinquency the only reason you are listed on the LEIE? ☐ Yes ☐ No

If you responded "Yes" to any of the questions in this section, you must provide the following:

☐ **A written self-explanation** for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation.

☐ **Supporting documentation** including court dispositions or agency orders where applicable.

Documents in sections 8, 9, 10 and 11 must be sent to the board office at info@floridaspharmacy.gov, or mailed to:

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

12. APPLICANT SIGNATURE

I, the undersigned, state that I am the person referred to in this application for licensure in the state of Florida.

I recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to s. 456.067, F.S.

I am aware that my pharmacist license may be suspended or revoked if I violate any provision of Chapter 456, Chapter 465, and/or any laws or rules adopted pursuant thereto.

Florida law requires me to immediately inform the board of any material change in any circumstances or condition stated in the application which takes place between the initial filing and the final granting or denial of the license and to supplement the information on this application as needed.

Section 456.013(1)(a), F.S., provides that an incomplete application shall expire one year after the initial filing with the department.

Applicant Signature _____ Date _____
You may print out this application and sign it or sign it digitally. MM/DD/YYYY

Complete forms must be sent directly from the verifying agency to the board office at info@floridaspharmacy.gov, or mailed to:

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Board *of* Pharmacy
Internship or Work Experience - Form B

Part I: Applicant Information

Applicant Name: _____

Intern/Pharmacist License #: _____ Telephone Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Have you submitted an application for the Florida Pharmacist Examination? ☐ Yes ☐ No

Date Application Submitted: _____
MM/DD/YYYY

I hereby apply for internship or work experience credit as outlined below under supervision of:

Part II: Pharmacy Information

Supervising Pharmacist Name: _____ License #: _____

Pharmacy Name: _____ Permit #: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: _____ Dates of Experience: From: _____ To: _____
MM/DD/YYYY MM/DD/YYYY

Average # of Hours Per Week: _____ Total Hours of Experience: _____

(No more than 50 hours per week if you are a student and no more than 60 after graduation are permitted.)

Applicant Signature _____ Date _____
MM/DD/YYYY

I state the statements on this report are true and correct. The above information was taken from the records of the above-named pharmacy which are available for inspection by the Board of Pharmacy.

Preceptor/Supervisor Signature _____ Date _____
MM/DD/YYYY

These hours must be pertinent to the Non-U.S. Graduate Registered Intern's program and statement(s) of attendance must be attached to this form. This form must be completed and forwarded to the board office within ten days of completion of the Foreign Graduate Registered Intern Work Activity Program.

Complete verifications must be sent directly from the licensing agency to the board office at info@floridaspharmacy.gov, or mailed to:

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Board *of* Pharmacy License Verification Request

Part I: To be completed by applicant (Florida requires verification of all your current and previously held licenses.)

Name: _____

Address: _____

Name original license was issued under: _____

License Number: _____ State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Pharmacy.

Applicant Signature: _____ Date: _____
MM/DD/YYYY

Part II: To be completed by state licensing agency

All verifications must be in English and include the following criteria:

* Typed on an official state form or letterhead
* Include an official board seal
* Signature and title of state board official

The following information must be included in all verifications:

* Licensee name
* License number
* State or jurisdiction of licensure
* Licensure status
* Is license in good standing?
* Date of issuance/expiration
* Licensure method (examination or reciprocity/endorsement)
* Has this license ever been encumbered (denied, revoked, suspended, surrendered, limited, placed on probation)?
* If this license has ever been encumbered, please provide certified copies of documentation regarding the action with the completed license verification.