



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243

<http://tn.gov/health/topic/pharmacy-board>

APPLICATION FOR PHARMACY TECHNICIAN REGISTRATION

The Tennessee Board of Pharmacy registers all Pharmacy Technicians practicing in the State of Tennessee. All required documentation must be filed with the Board in accordance with the rules and regulations.

1. **All applications fees are non-refundable**
2. The fee for pharmacy technician registration is \$95.00
3. **You must write your social security number on the application for it to be complete. State law requires social security numbers on this application. T.C.A. § 36-5-130 (a), as authorized by 42 U.S.C. § 405 (c)(2)(C)(i). The number will be used to verify your identity and for any other purpose allowed by state or federal law.**
4. All documentation and fees are required to be submitted by you, must be mailed directly to:

**Tennessee Board of Pharmacy
665 Mainstream Drive
Nashville, TN 37243**

5. Complete the Pharmacy Technician Affidavit- This form **must** be kept on file at the pharmacy where you are employed. **DO NOT SEND TO THE BOARD.**
6. The certificate must be displayed at the technician's place of employment
7. Allow ten (10) working days for information mailed to our Office to be received and placed in your file. Federal Express or special courier service will not reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred.
8. You are required to notify the Board within fourteen (14) business days of a change in employment.

Pursuant to board rule 1140-1-03(5): It shall be unlawful for any person to procure or attempt to procure a license or certificate of registration for such person or for any other person by making any false representation.

- ___ 1. **Application:** Complete the application, sign and mailed to the Tennessee Board of Pharmacy with all required documentation
- ___ 2. **Payment methods:** You may make the personal/business check or money order payable to the Tennessee Board of Pharmacy.
- ___ 3. **Declaration of Citizenship:** Please complete and submit along with your application the Declaration of Citizenship available online at <http://tn.gov/health/article/pharmacy-applications>.
- ___ 4. **Criminal Background Checks is Required:** For instructions to obtain a criminal background check, go to <http://tn.gov/health/article/CBC-instructions>. **Please use OCA code 9906.**
- ___ 5. **COMPETENCY INFORMATION:** Please read the questions in the Competency Information section of application carefully. You must answer "Yes" or "No" to **every** question. **If any of your answers to were in the affirmative, please explain the situation.** In addition to your explanation, the final documents or orders from the issuing states, courts and/or agencies must be submitted.
- ___ 6. If your application is not complete upon receipt by the board's administrative office, a deficiency letter will be sent to you by mail. Your application will expire one (1) year from the date of receipt.



STATE OF TENNESSEE
 DEPARTMENT OF HEALTH
 DIVISION OF HEALTH LICENSURE AND REGULATION
 OFFICE OF HEALTH RELATED BOARDS
 665 MAINSTREAM DRIVE
 NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF PHARMACY
 PHONE: (615) 741-2718 FAX: (615) 741-2722
<http://tn.gov/health/topic/pharmacy-board>

FOR OFFICIAL USE ONLY	
FEES	
9906-001	\$ 85
9906-006	\$ 10
	\$ 95

APPLICATION FOR PHARMACY TECHNICIAN REGISTRATION

 (Last Name) (First Name) (Middle)

 (Street Number)

 (City) (State) (Zip Code)

Are you a U. S. Citizen: Yes ___ No ___ Race: _____ Gender: _____
 All applicants must complete the Declaration of citizenship form

Birth: _____ Home Phone No.: _____
 (MM/DD/YYYY) Social Security Number

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. Yes ___ No ___

Email address: _____

Are you a member of the U.S. armed forces who has, within the preceding 180 days, retired from the armed forces, received any discharge other than a dishonorable discharge from the armed forces, or been released from active duty to a reserve component of the armed forces? (If yes, please provide proof of status.) Yes ___ No ___

Are you the spouse of a member of the armed forces who has been transferred by the military to Tennessee or who has, within the preceding 180 days, retired from the armed forces, received a discharge other than a dishonorable discharge from the armed forces or been released from active duty to a reserve component? (If yes, please provide proof of same.) Yes ___ No ___

Have you previously applied for a pharmacy technician registration in Tennessee? Yes ___ No ___

Practice Address: _____
 (Pharmacy Name)

 _____ Zip _____

Pharmacy Phone Number: (_____) _____

Type of Practice (circle one): Retail/Community Hospital/Institution Long Term Care Nuclear Not practicing

Competency Information

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;
 - b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.
3. **"Minor Traffic Offense"** generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.
4. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
5. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.
6. **"Illegal use of illicit or controlled substances"** means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: Please respond to ALL questions. If you answer "YES" to any question, please attach a written explanation.			
		YES	NO
1.	Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____
2.	Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? If so, please list: _____	_____	_____
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	_____	_____
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	_____	_____
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	_____	_____
<i>[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]</i>			

COMPETENCY INFORMATION

(continued)

		YES	NO
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice as a pharmacy technician in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	_____	_____
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	_____	_____
10.	Have you ever been rejected or censured by a professional association or society?	_____	_____
11.	In relation to the performance of your professional services in any profession: a. Have you ever had a final judgment rendered against you; b. Have you ever entered into any settlement of any legal action; or c. Are there any legal actions pending against you or to which you are a party?	_____ _____ _____	_____ _____ _____
12.	Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	_____	_____
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	_____	_____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Did you attend a pharmacy technician program? Yes ___ No ___

If yes, please provide the following information for the pharmacy technician program you have attended. Use the back of this page if you need additional space.

Educational Institution	City, State	Major	Graduated
_____	_____	_____	_____

Please complete your entire healthcare employment history starting with the most current position first. Use the back of this page, if you need additional space. Dates of employment must be included.

<u>Company/ Employer:</u>	<u>Address:</u> (City, and State)	<u>Position:</u>	<u>Duties:</u>	<u>Dates</u> <u>From: To:</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Previous Licensure

Are you or have you ever been licensed in this profession in another state?	YES	NO
	_____	_____
Are you or have you ever been licensed in any other profession in Tennessee or another state?	_____	_____

List below **ALL STATES, COUNTRIES, OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED, PERMITTED, OR CERTIFIED.** Additional pages may be added if necessary.

STATE	PROFESSION	LICENSE NUMBER	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____

AFFIDAVIT AND RELEASE

I, _____, of _____,
 (Applicant's Name) *(City)* *(State)*

being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a pharmacy technician in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a pharmacy technician.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without the malice concerning my competence, ethics, character, other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ **SIGNATURE**

_____ **DATE**