

**STATE OF UTAH**  
**DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING**  
**APPLICATION FOR LICENSURE**  
**PHARMACY INTERN**

**APPLICATION INSTRUCTIONS AND INFORMATION**

**General Statement:** The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents and fees.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

**Address of Record:** The address you provide on this application will be your address of record. All correspondence from DOPL will be sent to that address. You are responsible to directly notify DOPL of any change to your address of record. Do not rely on a forwarding order.

**Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a)(13). If an SSN is not provided, the application is incomplete and may be denied.

**SUPPORTING DOCUMENTS AND FEES:**

**In addition to submitting a completed application, complete the following:**

1. Submit one of the following documents:
  - If you have been accepted to an ACPE accredited pharmacy school, submit a completed “Statement of Pharmacy School Dean” form (*attached to this application*).
  - If you are enrolled in a graduate residency program and have not completed all required intern hours, submit a completed “Statement of Residency Program Director” form (*attached to this application*).
  - If you graduated from a foreign pharmacy school, submit a certificate of equivalency from FPGE.
2. Bring your completed application to DOPL’s offices (160 E. 300 S., Main Lobby, Salt Lake City) to complete electronic fingerprinting using DOPL’s Identix equipment.

**OR**

Submit **two** applicant fingerprint cards (Form FD-258: white with blue lines) to be used by DOPL for a search through the files of the Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigation (FBI). See “Additional Important Information.”

3. Submit a **\$140.00** non-refundable application-processing fee, made payable to “DOPL.” This fee includes a \$100.00 application fee for a pharmacy intern license, a \$20 surcharge for a BCI fingerprint file search, and a \$20 surcharge for a FBI fingerprint file search.

#### **ADDITIONAL IMPORTANT INFORMATION:**

1. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice as a pharmacy intern. The following laws and rules are available on the Internet at [www.dopl.utah.gov](http://www.dopl.utah.gov):
  - Division of Occupational & Professional Licensing Act
  - General Rules of the Division of Occupational & Professional Licensing
  - Pharmacy Practice Act
  - Pharmacy Practice Act Rule
  - Utah Controlled Substances Act
  - Utah Controlled Substances Act Rule
2. **Current Documents:** Applications, statutes, rules, and forms are occasionally changed. Go to [www.dopl.utah.gov](http://www.dopl.utah.gov) to ensure you have the most recent version of these documents.
3. **Issuance of Pharmacy Intern License:**
  - If you have been accepted to an accredited pharmacy school or if you are a resident or fellow in a program accredited by the Accreditation Council on Pharmaceutical Education, you may be issued an intern license for no longer than 5 years.
  - If you are a graduate from a foreign pharmacy school who has a certificate of equivalency from the Foreign Pharmacy Graduate Examination Committee of the National Association of Boards of Pharmacy Foundation, you may be issued an intern license for no longer than 1 year.
4. **License Renewal:** Pharmacy Intern licenses are **non-renewable**.
5. **Fingerprint Information:** All applicants are required to undergo a criminal background check and fingerprint search through the files of the Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigation (FBI). **Fingerprint cards that are not complete and/or properly rolled will be rejected, delaying the licensure process.**

To expedite the licensure process, you can obtain electronic fingerprinting at DOPL’s offices (160 E. 300 S., Salt Lake City), 8:00 a.m. to 4:30 p.m., Monday through Friday, except holidays. Currently, there is no fee to roll electronic fingerprints for DOPL licensure applicants. A current government issued picture ID is required.

If you are unable to obtain electronic fingerprints at DOPL’s office, you must include two (2) blue fingerprint cards (Form FD-258) with your application. Fingerprint cards are supplied with the application if obtained from DOPL. If you downloaded the application from the Internet, you may obtain fingerprint cards from DOPL, the Bureau of Criminal Identification (BCI), or your local police station. **To have your fingerprints rolled onto the blue fingerprint cards, you must go to BCI or a local police station.**

#### **BUREAU OF CRIMINAL IDENTIFICATION (BCI) INFORMATION:**

- Check with BCI for pricing of their services

- Walk-ins only; no appointments taken
- Fingerprinting and Photo Services are available from 8:00 a.m. – 5:00 p.m., Monday - Friday except holidays
- Government-issued picture ID required (*driver's license, state ID, passport, etc.*)
- Website: [www.bci.utah.gov](http://www.bci.utah.gov)
- Phone: (801) 965-4569
- Address: 3888 W. 5400 S., Taylorsville, UT 84118  
(1/2 block west of Bangerter Highway, behind McDonalds)

**WARNING:** If information received from the Utah Bureau of Criminal Identification or the Federal Bureau of Investigation indicates that you have failed to accurately disclose your criminal history to the Division of Occupational and Professional Licensing, any pharmacy license issued to you will be immediately and automatically revoked.

**REVIEW OF YOUR FBI RECORD:** If you wish to challenge the accuracy of the information in your FBI record, you should contact the agency that contributed the information in question. You may also direct the challenge to the FBI, Criminal Justice Information Services (CJIS) Division, Attn. SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.

7. **Updating Address Information:** It is your responsibility to maintain a current address with DOPL. If your address is incorrect, you will not receive renewal notices or other correspondence. Address changes can be made online at [www.dopl.utah.gov](http://www.dopl.utah.gov).
8. **Name Change:** If you have been licensed by DOPL under any other name, please submit documentation of your name change (*i.e. copy of a marriage license or divorce decree*).
10. **Acceptable Forms of Payment:** License fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.
11. **Mail Complete Application to:**
  - By U.S. Mail**  
 Division of Occupational & Professional Licensing  
 P.O. Box 146741  
 Salt Lake City, Utah 84114-6741
  - By Delivery or Express Mail**  
 Division of Occupational & Professional Licensing  
 160 East 300 South, 1<sup>st</sup> Floor Lobby  
 Salt Lake City, Utah 84111
12. **Telephone Numbers:** (801) 530-6628  
(866) 275-3675 – Toll-free in Utah
13. **Email:** [doplbureau3@utah.gov](mailto:doplbureau3@utah.gov)

# APPLICATION FOR LICENSURE

## GENERAL INFORMATION

License Applying For: **PHARMACY INTERN**

<b>***Please list your <u>full legal name</u> as it appears on your driver's license, Social Security Card, etc.***</b>			
Last Name:		First Name:	
Social Security Number:     -     -		Maiden Name:	
I certify under penalty of perjury that:			
<input type="checkbox"/> I am a citizen of the United States and I have a valid US Driver License or US State ID. License/State ID Number: _____ State: __			
<input type="checkbox"/> I am a citizen of the United States currently living outside the United States and do not have a valid US Drivers License or US State ID. Please attach a legible copy of your valid passport or other documentation to verify you are a legal citizen of the United States.			
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I have a valid US Drivers License or US State ID. License/State ID Number: _____ State: __			
<input type="checkbox"/> I am a non-citizen of the United States, who is lawfully present in the United States and I do not have a valid US Drivers License or US State ID. Please attach a legible copy of your current and valid government issued document showing evidence of authorization to work in the United States.			
<input type="checkbox"/> I am a foreign national not physically present in the United States.			
Mailing Address:			
City:			State:     ZIP:
<input type="checkbox"/> Male	Date of Birth:	Phone #:	E-Mail:
<input type="checkbox"/> Female			
List all other licenses, registrations, or certifications issued by any state which you now hold or have ever held in any profession. <i>(Use additional sheets if necessary.)</i>			
Profession:		Issuing State:	
License Number:		License Status:	Issue Date:
Profession:		Issuing State:	
License Number:		License Status:	Issue Date:
Profession:		Issuing State:	
License Number:		License Status:	Issue Date:
Profession:		Issuing State:	
License Number:		License Status:	Issue Date:

<b><i>DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY</i></b>	
License/Certificate Number: _____	
Date License/Certificate Approved: ____/____/____	
Approved By: _____	
Date License/Certificate Denied: ____/____/____	
Denied By: _____	
Reason for Denial/Other Comments: _____	

**AFFIDAVIT and RELEASE AUTHORIZATION**

1. I certify that am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, forgery, misrepresentation, omission of material fact; is truthful, correct, and complete; discloses all material facts regarding the applicant; and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, institutions, organization, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Signature of Applicant: \_\_\_\_\_ Date of Signature: \_\_\_/\_\_\_/\_\_\_\_\_

**EDUCATION**

**Please complete this section in respect to the pharmacy school you are attending.**

School Name: \_\_\_\_\_

Location: \_\_\_\_\_

Date of Attendance: \_\_\_\_\_ To \_\_\_\_\_ Proposed Date of Graduation: \_\_\_/\_\_\_/\_\_\_\_\_

Degree to be earned: \_\_\_\_\_

Answer “yes” or “no.”

\_\_\_\_\_ I have been accepted to an ACPE Accredited Pharmacy School and have attached a “Statement of Pharmacy School Dean” form.

\_\_\_\_\_ I am a resident or fellow in a program accredited by ACPE and have attached a “Statement of Residency Program Director” form.

\_\_\_\_\_ I am a graduate from a foreign pharmacy school and have attached my certificate of equivalency from FPGEC.

# PHARMACY INTERN QUALIFYING QUESTIONNAIRE

Answer “yes” or “no” for each question. Do not leave any question blank.

1. \_\_\_\_\_ Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
2. \_\_\_\_\_ Have you ever been denied the right to sit for a licensure examination?
3. \_\_\_\_\_ Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
4. \_\_\_\_\_ Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any health care professional licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
5. \_\_\_\_\_ Are you currently under investigation or is any disciplinary action pending against you now by any licensing agency or governmental agency?
6. \_\_\_\_\_ Have you ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
7. \_\_\_\_\_ Have you ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending against you by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
8. \_\_\_\_\_ Is any action related to your conduct or patient care pending against you now at any hospital or health care facility?
9. \_\_\_\_\_ Have you ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
10. \_\_\_\_\_ Have you ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending against you by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
11. \_\_\_\_\_ Is any action pending against you now by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
12. \_\_\_\_\_ Have you ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?

*(Continued on the next page.)*

13. \_\_\_\_\_ Have you ever been permitted to surrender your registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending against you by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
14. \_\_\_\_\_ Is any action pending against you now by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
15. \_\_\_\_\_ Have you been named as a defendant in a malpractice suit?
16. \_\_\_\_\_ Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
17. \_\_\_\_\_ Have you ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
18. \_\_\_\_\_ If you are licensed in the occupation/profession for which you are applying, would you pose a direct threat to yourself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
19. \_\_\_\_\_ Have you ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
20. \_\_\_\_\_ Have you been terminated from a position because of drug use or abuse within the past five (5) years?
21. \_\_\_\_\_ Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
22. \_\_\_\_\_ Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law?
23. \_\_\_\_\_ Have you ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which you have not successfully completed or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
24. \_\_\_\_\_ Do you currently have any criminal action pending?
25. \_\_\_\_\_ Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.

(Continued on the next page.)

26. \_\_\_\_\_ Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
27. \_\_\_\_\_ Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (*i.e. plea in abeyance or deferred sentence*)?
28. \_\_\_\_\_ Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?



**If you answered “yes” to questions 24, 25, 26, 27, or 28 above, you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).**

**If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.**

**If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.**



**If you answered “yes” to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.**

**A “yes” answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.**

## STATEMENT OF PHARMACY SCHOOL DEAN

### TO BE COMPLETED BY APPLICANT ACCEPTED TO PHARMACY SCHOOL:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### TO BE COMPLETED BY THE DEAN OR AN AUTHORIZED REPRESENTATIVE OF THE PHARMACY SCHOOL:

Name of Pharmacy School: \_\_\_\_\_

Name of Dean/Authorized Representative: \_\_\_\_\_

Title: \_\_\_\_\_

I am the Dean or an authorized representative of the pharmacy school named above. I understand the above named applicant is applying for an intern license. I certify that said applicant has been accepted as a pharmacy student and has successfully completed all pre-professional college education required by the accredited pharmacy school named above.

Signature of Dean/Authorized Representative: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Official Agency Seal)

## STATEMENT OF RESIDENCY PROGRAM DIRECTOR

### TO BE COMPLETED BY APPLICANT ENROLLED IN A GRADUATE RESIDENCY PROGRAM WHO HAS NOT COMPLETED INTERN HOURS REQUIREMENT:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### GRADUATE RESIDENCY PROGRAM:

Name of Program: \_\_\_\_\_

Location: \_\_\_\_\_

Dates Attending: from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Residency Program Director: \_\_\_\_\_

### TO BE COMPLETED BY RESIDENCY DIRECTOR:

I am the Director of the graduate residency program. I understand that the applicant is applying for an intern license. I certify that the applicant has been accepted to the graduate residency program named above.

Signature of Program Director: \_\_\_\_\_

Name of Program Director: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

(Official Agency Seal)