STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH RELATED BOARDS
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
PHONE: (615) 741-2718 FAX: (615) 741-2722
https://www.tn.gov/health/health-program-areas/health-professional-boards/pharmacy-board.html

APPLICATION FOR PHARMACIST EXAMINATION

Prior to being admitted to the NAPLEX® examination, applicants for licensure as a pharmacist must meet all preliminary requirements. All required documentation must be filed with the Board in accordance with the rules and regulations.

1. **All application fees are non-refundable.**
2. Applicants must be at least 21 years of age, and be a graduate of an accredited college of pharmacy. The Tennessee Board of Pharmacy interprets the term "graduated" to mean that the student has completed the actual graduation process and has received a diploma.
3. A minimum of 1,700 (seventeen hundred) pharmaceutical internship hours are required for licensure. Applicants must submit affidavits attesting to internship hours acquired in Tennessee with the application. **Out of state applicants applying by examination/score transfer must have their State Board of Pharmacy certify the number of internship acquired directly to the Tennessee Board of Pharmacy.**
4. **You must write your social security number on the application for it to be complete. State law requires social security numbers on this application. TCA § 36-5-1301(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.**
5. All documentation and fees are required to be submitted by you, or which must be requested from the appropriate institutions or state board of pharmacies in the application process, must be mailed directly to

   Tennessee Board of Pharmacy
   665 Mainstream Drive
   Nashville, TN 37243

6. Allow fourteen (14) working days for information mailed to our Office to be received and placed in your file. Federal Express or special courier services will not reduce the processing time. Additionally, if Federal Express or special courier services are used, you will be responsible for charges incurred.

INITIAL TENNESSEE CANDIDATES	**$235.00 FEE**

SCORE TRANSFER CANDIDATES	**$485.00 FEE**

***FOREIGN GRADUATES**	**$235.00 FEE**

***FOREIGN GRADUATES must complete:**

- **At least 500 internship hours in Tennessee within period of six (6) consecutive months.**
- **Submit a copy of FPGEC® certification with application.**

Tennessee does <u>not</u> License or Register Interns.
This includes Foreign Graduates.

Internship

Pharmacy Intern means a person enrolled or a graduate of an ACPE accredited school or approved College of Pharmacy, under rules established by the Board, who is serving a period of time of practical experience under the supervision of a pharmacist as defined in the rules of the Board.

1. Prior to licensing by the Tennessee Board of Pharmacy, an applicant must show proof that he/she has acquired at least 1,700 (seventeen hundred) hours of internship after enrollment in a ACPE accredited College of Pharmacy. Internship Affidavit forms will be kept in the Pharmacy Board file for a period of two years prior to receipt of NAPLEX Application.

    - *Enrollment in a College of Pharmacy as interpreted by the Board of Pharmacy to mean after the actual date of the student's physical attendance at the school.*

2. Intern hours may be acquired in another state provided the internship is certified by the respective State Board. Intern hours are transferable from state to state as requested by the student. Intern hours must be certified by the Director of the State Board in the state where the hours of internship are earned.

3. In addition to the requirements (1) and (2), foreign pharmacy graduates shall complete five hundred (500) hours of pharmacy internship in Tennessee within a period of six (6) consecutive months prior to licensure. Those who have acquired their entire seventeen hundred (1700) hours in the State of Tennessee will not be required to obtain an additional five hundred (500) hours in Tennessee.

4. Only one intern may dispense under the direct supervision of a preceptor in any specific time period.

5. No specific amount of internship hours are required prior to taking the NAPLEX examination.

Checklist for Initial/Score Transfer Pharmacist Graduates Licensure in Tennessee

___1. **APPLICATION:** Complete the application, **sign and have notarized** and mail to the Tennessee Board of Pharmacy with all required documentation.

___2. **PHOTOGRAPH:** Attach a photograph (passport size) in the space provided on the application.

___3. **INTERNSHIP HOURS:** A minimum of 1700 internship hours are required in Tennessee. Internship hours are not required to sit for the NAPLEX, but are required before your license can be issued. **Hours acquired in other states must be certified by the respective state board of pharmacy prior to submission to the Tennessee Board of Pharmacy.**

___4. **MANDATORY PRACTITIONER PROFILE (Consumer Right to Know Act):** Complete and submit along with your application the *Practitioner Profile Questionnaire* which is online at https://www.tn.gov/health/health-program-areas/health-professional-boards/pharmacy-board/pharmacy-board/applications.html. You are required by law update your profile within 30 days of any change as long as you have an active license. Failure to do so may subject you to disciplinary action

___5. **PAYMENT METHODS:** You may make the personal/business check or money order payable to the Tennessee Board of Pharmacy. Fees submitted to the Tennessee Board of Pharmacy are non-refundable.

___6. **DISABILITY:** If you have any type of disability that would require specific accommodations, please download the Disability Accommodation form from the Tennessee Board of Pharmacy website at: https://www.tn.gov/content/dam/tn/health/documents/ADA_form_123112_FINAL_(1)_(1).pdf

___7. **COMPETENCY INFORMATION:** Please read the questions in the Competency Information section of the 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.

___9. **DECLARATION OF CITIZENSHIP:** Complete and submit along with your application the Declaration of Citizenship available online athttps://www.tn.gov/health/health-program-areas/health-professional-boards/pharmacy-board/pharmacy-board/applications.html

___10. **CRIMINAL BACKGROUND CHECKS IS REQUIRED-**For instructions to obtain a criminal background check, go to https://www.tn.gov/health/health-professionals/criminal-background-check/cbc-instructions.html

___11. **Examinations**: You must successfully take and pass the North American Pharmacist Licensure Examination (NAPLEX) and the Multistate Pharmacy Jurisprudence Examination (MPJE). You may register and pay for both exams at www.nabp.net.

___12. **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.**

TAPE A CURRENT, FULL-FACE SIGNED PHOTOGRAPH HERE

(SIGNED BY APPLICANT ON THE FRONT OF THE PHOTO)

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FOR OFFICIAL USE ONLY

FEES

Initial TN and Foreign Grads

9901-001	$ 225
9901-006	$ 10
	$ 235

Score Transfer

9901-001	$ 475
9901-006	$ 10
	$ 485

INDICATE TYPE OF CANDIDATE

NAPLEX _____ **SCORE TRANSFER** _____ **FOREIGN GRADUATE** _____

_____ _____ _____
Name (First) *(Middle)* *(Last)*

_____
Mailing Address

_____
(City) *(State)* *(Zip Code)*

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

Date of Birth ____ ____ ____ _____ _____
(Month) *(Day)* *(Year)* (Gender) *(Social Security Number)*

Home Phone No. (____) _____ Cell/Work Phone No.(____) _____

Email address: _____

Do you wish to receive notification, including renewal notification, from the 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 _____

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 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 status.) Yes _____ No _____

Have you previously applied for a pharmacist license in Tennessee? Yes _____ No _____

Have you ever taken other state board examinations? Yes _____ No _____

If yes, list the dates and states where examinations were taken _____

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?	____	____
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice as a pharmacist 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?	____	____
[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.]			

COMPETENCY INFORMATION
(continued)

		YES	NO
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)		
14.	Have you ever failed a pharmacist examination?		
	If yes, which exam and how many times have you failed? _____		

Do you have a DEA number? Yes ____ No ____ If yes, what is the number(s)? _____

If you have an NPI number, please provide _____

Education and Internship History

List all college training completed:

Name and Location of College Attended	Period of Attendance

Number of hours completed in Internship: _____ Date Started:_____ Date Ended:_____

Previous Licensure

	YES	NO
Are you or have you ever been licensed in this profession in another state?		
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. Request that verification of licensure be submitted directly to the Board's Office from each state.

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 pharmacist 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 pharmacist.

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 malice concerning my competence, ethics, character, and/or 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**

COLLEGE CERTIFICATION

(To be completed by College of Pharmacy)

This is to certify that _____

was in regular attendance at the _____

FROM _____ TO _____

FROM _____ TO _____

FROM _____ TO _____

FROM _____ TO _____

A total of _____ months and a Certificate of Graduation with the degree of _____

Issued on _____ or is scheduled to be Issued on _____

(If scheduled to graduate at a future date, the college will be responsible for advising the Board if for any reason the student does not graduate.)

(School Seal) _____

(*Signature of Authorized Representative)*

_____ _____

(Name Printed) *(Title)*

DIRECTOR _____

Mail to: Tennessee Board of Pharmacy
665 Mainstream Drive
Nashville, TN 37243