

VIRGIN ISLANDS BOARD OF PHARMACY

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Department of Health 3500 Estate Richmond Christiansted, VI 00820-4370 Tel: 340-718-1311 xt 3647 or 3849

To Whom It May Concern:

Thank you for your recent request for information regarding licensure for the Practice of Pharmacy in the U.S. Virgin Islands.

The Virgin Islands Board of Pharmacy is now an active member of the National Association of Boards of Pharmacy (NABP). As such, we are also a member of the Licensure Transfer Program. Since you are licensed in another state(s) you can access the NABP website at <u>www.napb.net</u> for the application for Licensure Transfer. Once the application has been cleared by NABP, the Board will make its final decision and inform you.

You are also required to complete and submit our Pharmacy application, which is enclosed. If you have any questions, you may contact the Board at the above numbers.

Thank you for your interest.

Sincerely,

Laura M. Forbes, R.Ph. Secretary, V.I. Board of Pharmacy

Enclosure



BOARD OF

VIRGIN ISLANDS

PHARMACY

APPLICATION FOR PHARMACIST LICENSE

A non-refundable application fee of \$25.00 (check or money order) is required with application.

NOTE

ANY FALSE OR MISLEADING INFORMATION IN CONNECTION WITH THIS APPLICATION MAYBE CAUSE FOR DEBARMENT ON THE GROUND OF LACK OF GOOD MORAL CHARACTER.

AFFIX PHOTO HERE

I hereby apply for licensure to practice Pharmacy in the U.S. Virgin Islands, in accordance with the terms set forth in Section 149 of Act 1714 - an Act to regulate the practice of Pharmacy in the U.S. Virgin Islands and other purposes.

	E-mail:			
Full Name:	Phone:			
Mailing Address:				
Date of Birth:	Place of Birth:			
Citizenship:	S.S.#			
Father's Name:				
Place of expected employment on Island:				
	(if applicable)			
PHARMACY COLLEGE TRAINING:				
I was granted a diploma of graduation from				
	on the day of	, the		
degree be	ing thereby conferred.			

PRACTICAL EXPERIENCE:

List work experience on resume to include, begin with present or last position held: Name of agency, address of agency, position held, responsibilities, supervisor, period of employment, reason for leaving.

REFERENCES: (One Personal and Two Professional)

Name			Address/Tele. No.			
LICENSURE RECORD:						
I am presently registered and in good	d standing in the	following States:				
State	License #	Date .	Acquired	Expir	ation Date	
(Enclose copies of licenses with app	-			·		
HAVE YOU EVER BEEN CHAR EMPLOYMENT TERMINATED OR AS SUCH PENDING? Yes _	FOR VIOLAT					
If Yes , explain						
I, PERSONALLY COMPLETED PARAGRAPHS AND THE DOCU MY KNOWLEDGE AND BELIE	THIS FORM JMENTS SUBN	AND THE INFO	ORMATION	IN THE F	OREGOINC	
		(A)	(Applicant sign name in full)			

(Notary Public)



REQUIREMENTS FOR LICENSURE AS A PHARMACIST IN THE VIRGIN ISLANDS

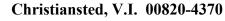
- 1. Submit application as prescribed by and obtained by the V.I. Board of Pharmacy along with all requested documents. **NOTE:** Any false or misleading information in connection with this application may be cause for debarment on the ground of Good Moral Character.
- 2. Submit a recent un-mounted photograph of passport size of himself/herself autographed across the back and dated.
- 3. Submit a chronological account of all time spent between the date of graduation from your pharmacy school and time of application.
- 4. Submit a copy of diploma/degree from a School or College of Pharmacy accredited by the American Council on Pharmaceutical Education or its successor.
- 5. Submit a copy of a license(s) from another state.
- 6. A non-refundable application fee of **\$25.00** made payable to Government of the Virgin Islands.
- 7. Complete licensure transfer process with NABP. Website: www.nabp.net
- 8. Submit a completed and **NOTARIZED** Authorization for Release of Information.
- 9. If foreign-trained, proof of Foreign Pharmacy Graduate Equivalency Examination Certification (FPGEC) is required.
- 10. Is not unfit or unable to practice pharmacy by reason of the extent or manner of his/her use of alcoholic beverages, narcotic and/or dangerous drugs or by reason of a physical or mental disability. Submit notarized non-addiction letter.
- 11. Be a good moral and professional character; who will properly carry out the duties and responsibilities required of a pharmacist; must be at least 21 years of age; a graduate of an ACPE accredited school of pharmacy.
- 12. All approved applicants must submit a VI tax clearance letter for license registration.

NOTATIONS:

♦ After reviewing your application, it may be necessary for you to take the MPJE/NAPLEX.

All applications and information for licensure should be submitted to:

VIRGIN ISLANDS BOARD OF PHARMACY Department of Health 3500 Estate Richmond





VIRGIN ISLANDS BOARD OF PHARMACY Department of Health 3500 Estate Richmond Christiansted, V.I. 00820-4370

VERIFICATION OF LICENSURE

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Application is requested to complete this section of the form and mail to each **State Board of Pharmacy** in which you are now or have been licensed to practice Pharmacy. You may copy this form if additional copies are needed. **State Board is to forward this form or its own verification form directly to: VI Board of Pharmacy**, **Department of Health**, **Department of Health 3500 Estate Richmond**, **Christiansted**, **V.I. 00820-4370**

TO:		(Name of Board)		
 I,	Address , here	Address, hereby authorize the Boa		
of Pharmacy to release to the disciplinary records and any o	Virgin Islands Board o ther information, which	of Pharmacy any info h is material to my a	prmation concerning my licensure status, application for licensure. Additionally, I e V.I. Board of Pharmacy in good faith.	
Applicant Signatu	ire		Date	
Address				
RETURNED DIRECTLY TO T Name of State Board: Full Name of Licensee: License No.:	THE VI BOARD OF PH	IARMACY AT THE		
Is license current and in good star		h details.		
Has any disciplinary action ever	been taken against the ab	ove named Pharmacist	? If YES, furnish details	
Comments, if any:				
		Signed: Title:		
BOARD SEAL				

Date:



VIRGIN ISLANDS BOARD OF PHARMACY

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Department of Health of Health 3500 Estate Richmond Christiansted, VI 00820-4370

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ______ hereby authorize all hospital(s), institution(s), or Organization(s) my references, employer(s) (past and present) and all Governmental Agencies and instrumentalities (local, state, federal or foreign) to release to the Virgin Islands Board of Pharmacy any information, which is needed for my licensure application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application or other information requested in relations to the application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Pharmacy in the Territory of the United States Virgin Islands.

Additionally, I release from liability any hospital or agency releasing such information to the Board of Pharmacy in good faith.

Notary Public

SEAL

My Commission Expires