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Kentucky Board of Pharmacy 125 Holmes Street, Suite 300 State Office Building Annex Frankfort, Kentucky 40601 Phone: 502-564-7910 Fax: 502-696-3806

License No.				
Date Issued				
NAPLEX Score				
MPJE Score (FOR OFFICE USE ONLY)				

## **Initial Application for Pharmacist Licensure**

This application and fee of \$150 must be in the Board Office before taking the NAPLEX or MPJE. Answer all questions in full and print legibly. **Please make checks payable to the 'Kentucky State Treasurer'.** 

I hereby make application for examination by the Kentucky Board of Pharmacy for license as a Pharmacist in Kentucky subject to the provisions of the statues and rules and regulations of the Board and being duly sworn submit the following:

1. Name				
2. Address				
	Street and Number			
3	State		Zip Code	
4. Telephone Number ( )	5. E-mail Address			
5. Date of Birth	_ 7. Sex (check one):	□Male	□Female	
3. Social Security No	9. Kentucky Pharmac	ist Intern Registration	Number	
11. Have you ever been convicted of a misdemear				Yes
(If addition 12. Have you ever failed or been refused an examNoYes If yes,	• •		er state licensing ager	ncy?
(If addition	nal space is needed for details, please	attach separate sheet)		
13. Have you ever been refused licensure by any SNoYes If yes,		or other state licensing	ng agency?	
	nal cases is peopled for details, places			
/If addition				

(If additional space is needed for details, please attach separate sheet)

14. Have you eve	er had a Certification	on of Registration as a	Pharmacist suspend	ded, probated, or revo	ked by any State	Board of
Pharmacy?	No	Yes If ye	es, give details:			
		(If additional space is	needed for details, please atta	ach separate sheet)		
I certify that the sta	atements contained i	n this application are tru	ue, complete, and corr	ect, and I agree that the	statements shall fo	orm the basis of m
application and I do	authorize the Kentu	icky Board of Pharmacy	to make any investigat	tions that they deem app	propriate and to see	cure any additiona
information concer	ning me, and I furthe	r authorize them to furni	ish any information the	ey may now or in the futu	re have concerning	g me to any person
corporation, institu	tion, association, Boa	ard or any municipal, cou	inty, state, or federal go	overnmental agencies or	units, and that I un	derstand according
to the Kentucky Re	vised Statutes a Pha	rmacist's License may b	e revoked or suspend	led for presenting any fa	lse, fraudulent, or	forged statement
certificate, diploma	a, or other thing, in co	onnection with an applic	cation for a license or p	permit.		
Signatur	e in Full					
Thereby certify that ti	ne above application wa	as signed, subscribed and st	worn to before the this _	day of		_ , 20
(	(Seal)		Signa	ature		
My commission expire	es		State	e of		
This certific	cate of moral charac	ter must be signed by a	person of good stand	ling in the community in	which the applica	nt resides.
l,		(	of		do say	y that the
applicant herein na	med, has been perso	onally known to me for _	years, that	t my acquaintance with tl	he applicant throu	ghout that period
has been sufficientl	ly intimate to afford	me ample opportunity to	o become fully informe	ed as to the applicant's m	noral character and	habits, that the
applicant is not add	dicted to the use of a	lcoholic liquors or drugs	so as to render the ap	plicant unfit to practice F	harmacy, that the	applicant is of
good moral charact	ter and that I recomn	nend the applicant, so fa	ar as character and hab	oits are concerned, as wo	rthy to be licensed	l to practice
Pharmacy in Kentuc	cky.					
	(Date)			(Signature)		
				\G=		
		(Occupation)				
		(Occupation)				

## **CERTIFICATION OF COLLEGE GRADUATION**

[To be executed by the Dean of the College of Pharmacy where the applicant attended Pharmacy School.]

Please make a copy of this section and submit to the Dean of the College of Pharmacy where you graduated for completion.

Please indicate below the College of Pharmacy attended.

This is to certify that	was in regular attendance at			
	and that a certificate of graduation with the degree			
was conferred on	<del>.</del>			
		(Signature)		
	(SEAL)	(Title)		
		(Date		

## **CERTIFICATION OF INTERN HOURS**

Please make a copy of this section and submit to the appropriate person[s] of the College of Pharmacy where you graduated or the State Board of Pharmacy if hours are outside of Kentucky for completion.

If cert	ifying agency is the College of P	harmacy, please co	omplete section A.		
[A] regula	This is to certify that r attendance				was in
at			and that	hours were accrued during rotations.	
If cert	ifying agency is a State Board o	f Pharmacy, please	complete section B.		
[B]	This is to certify that		\	while an intern with the	
		earned	hours.		
					(Signature)
	(SEAL)			(Title	)
				(Date	)

The Kentucky Board of Pharmacy does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of services and provides, upon request, reasonable accommodation, including auxiliary aids and services, necessary to afford individuals with disabilities an equal opportunity to participate in all programs and activities. Contact the Board for assistance.