Technician Dispensing in TrainingApplicants

This application cannot be returned by fax or email.
We must have an original signature(s) and fee to process.

Download application and mail to the address on the top of the application with the required $40.00 fee. The fee is payable by money order or cashier's check only, we do not accept personal or business checks, cash or credit cards. If the application is received with a personal check or cash, it will be returned and will delay the processing of your application.

Fee is made payable to : ***Nevada State Board of Pharmacy***

Before calling with questions, please read all information carefully

You must submit the application prior to starting the required 500 hours.

Upon receipt of the completed application and fee, a certificate of registration can be sent directly to the dispensing pracitioner's office.

All dispensing technician in training registrations expire October 31 of the even numbered years, no matter when the license is issued. It is your responsibility to keep us up to date with your address. If you have any questions, please feel free to contact the Reno office.

NEVADA STATE BOARD OF PHARMACY
985 Damonte Ranch Pkwy Ste 206 – Reno, NV 89521
TECHNICIAN DISPENSING IN TRAINING APPLICATION
Registration Fee: $40.00** - **(non-refundable, cashier's check or money order only, no checks)

First:______________________Middle:_______Last:____________________________

Home Address:____Apt #: _

City:_____________________________ State:_________ Zip Code: _______________

Telephone:_______________________ SS# or ITIN:_______________________________

Date of Birth:_______________ Place of Birth:____________________________Sex: M or F

E-mail Address: ____

I am requesting registration at the following dispensing pracitioner's office:

Dispensing Practitioner: ____

Practice Name: ____

Address:____

City:____State:______________Zip Code: __________

Signature of Dispensing Practitioner: ____

(Without the signature of the dispensing practitioner, the application will be returned.)

1. Are you 18 years of age or older? Yes No
2. Are you a high school graduate or the equivalent? Yes No

(**IF YOU ANSWERED "NO" TO QUESTION 1 AND/OR 2, YOU CAN NOT SUBMIT THIS APPLICATION**)

Yes No

Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?..

3. Been charged, arrested or convicted of a felony or misdemeanor in any state?.........................
4. Been the subject of an administrative action whether completed or pending in any state?...........
5. Had your license subjected to any discipline for violation of pharmacy or drug laws in any state?

If you marked **YES** to any of the numbered questions (**3-5**) above, include the following information & **provide documentation**:

Board Administrative Action:	State	Date:	Case #:
		/ /	

Criminal Action:	State	Date:	Case #:	County	Court
		/ /			

In response to federally mandated requirements, the Nevada Legislature and Attorney General require that we include the following questions as part of the application.

Are you the subject of a court order for the support of a child?... Yes No
IF you marked YES to the question, above are you in compliance with the court order?.. ...... Yes No

I hereby certify that the information furnished on this document is true and correct. I agree to abide by all the statutes, rules and regulations governing pharmaceutical technicians in training and understand that a violation of any such statutes, rules and regulations may be grounds for suspension or revocation of this permit.

_______________________________________ ____________________
Original Signature, no copies or stamps accepted Date

Board Use Only
Received:________________________Amount:_________________________Entity # _____________

DISPENSING PRACTITIONER CERTIFICATION OF TECHNICIAN DISPENSING HOURS

**(This form is submitted after hours after been completed.
DO NOT submit with the application.)**

Dispensing Technician: ____

Dispensing Practitioner: ____

Address:____

City:______________________________State:__________________Zip:______________

Telephone:____________________________________Fax: ________________________

E-mail: ____

I certify to the Board that the above named dispensing technician has successfully completed **________________hours of training and experience and is competent to perform the tasks of a dispensing technician.

** A minimum of 500 hours is required.

____ ________________

Dispensing Practitioner Date