

## NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Parkway, Suite 206 - Reno, NV 89521 - (775) 850-1440

### Dispensing Technician in Training (TDT) Application

**Non-Refundable \$50 fee**

Rev (03/17/2023)

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

If you will be working as a “pharmaceutical technician in training” at a pharmacy, DO NOT COMPLETE THIS APPLICATION. Complete the “Pharmaceutical Technician in Training” application at [www.bop.nv.gov](http://www.bop.nv.gov).

Approval of this application is required to request a Dispensing Technician in Training (TDT) registration. A TDT registration is a revocable privilege, and no holder of such a license acquires any vested right therein or thereunder.

A TDT registration is required for an individual to participate and acquire the necessary experience and training, of at least **1,500 hours**, providing the services set forth in NAC 639.742(4), under the direct supervision of at least one dispensing practitioner, to become a dispensing technician (TD). **Alternatively**, if you have an active pharmaceutical technician registration, in good standing in this State, you may directly apply for a TD registration.

Print and mail the completed application to the address indicated above with a **non-refundable fee of \$50.00** paid for by credit or debit card or a check, cashier’s check or money order made payable to the Nevada State Board of Pharmacy. Credit and debit card payments are charged a 5% processing fee.

#### **Please note:**

- Access Nevada Revised Statutes and Administrative Codes for pharmacy practice at [www.bop.nv.gov](http://www.bop.nv.gov).
- A TDT shall notify the Board on a form prescribed by the Board within 10 days after changing or adding a location of practice; or a dispensing practitioner by whom the TDT is being supervised. NAC 639.7435.
- All TDT registrations expire October 31 of even-numbered years. Fees are not pro-rated.
- For questions contact us at 775-850-1440 or by email at [pharmacy@pharmacy.nv.gov](mailto:pharmacy@pharmacy.nv.gov).

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**Section 1: General Information**

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SSN or ITIN: \_\_\_\_\_ Sex:  M  F  X  
Mailing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**Section 2: Employment Information**

Dispensing Practitioner Name: \_\_\_\_\_ Dispensing Practitioner Registration #: \_\_\_\_\_  
Name of Dispensing Practitioner Site: \_\_\_\_\_  
Dispensing Practice Site Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

<b>Section 3: Age and Education Requirements (You do not qualify to be a TDT if you answer "NO" in this section.)</b>	<b>Yes</b>	<b>No</b>
1. Are you 18 years of age or older?		
2. Are you a high school graduate or the equivalent?		
High School Name: _____ Graduation Date OR Date GED obtained (mm/yy): _____ Address: _____ City: _____ State: _____ Zip: _____		

<b>Section 4: Federally Mandated Requirement (NRS 425.520, NRS 639.129)</b>	<b>Yes</b>	<b>No</b>
1. Are you the subject of a court order for the support of a child? (If "yes", answer question 2.)		
2. Are you in compliance with the order or the plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order?		

<b>Section 5: Military Service (NRS 622.120)</b>	<b>Yes</b>	<b>No</b>
1. Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		
2. Have you ever been assigned to duty for a minimum of 6 continuous years in the National Guard or a reserve component of the Armed Forces of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		
3. Have you ever served the Commissioned Corps of the United States Public Health Service or the Commissioned Corps of the National Oceanic and Atmospheric Administration of the United States in the capacity of a commissioned officer while on active duty in defense of the United States and separated from such service under conditions other than dishonorable? (Mark "Yes" if discharged honorably.)		

Section 6: Personal and Professional History	Yes	No
1. Have you 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 registration?		
2. Have you been charged, arrested, or convicted of a felony or misdemeanor in <u>any</u> state even if the case or charge has been dismissed, sealed, acquitted, or expunged?		
3. Have you been the subject of a board citation or administrative action whether completed or pending in <u>any</u> state?		
4. Has your license/registration been subjected to any discipline for violation of pharmacy or drug laws in <u>any</u> state?		

Please use and make copies of this page (if necessary) to provide information regarding any questions, 1-4, you have marked "YES" to in section 6 of the application. A signed statement of explanation for each event and a copy of all documents that identify the circumstance or contain an order, agreement or other disposition for the event must be provided.

This is in response to Question # \_\_\_\_\_. Provide all the following *where applicable*:

Date of Event/Arrest	Disposition Date	State	City	County
Case #		Governing, licensing, Arresting Presiding Body/Agency/Court		
Reason/Charge				
Plaintiff/Defendant/Claimant/Respondent			Lawsuit/Arbitration/Bankruptcy	
Name of Business/Industry/Entity				

Provide explanation below:

\_\_\_\_\_  
Original Signature (electronic, copies or stamps not accepted)

\_\_\_\_\_  
Date

I certify under penalty of perjury that the information contained in this application is accurate, true and complete in all material respects. I understand that making any false representation in this application is a crime under NRS 639.281. I understand that pursuant to NRS 239.010, this entire application and any portion thereof is a public record unless otherwise declared confidential by law, and will be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020. In the event this application is approved I agree to comply with all applicable federal and state statutes and regulations governing this license or registration and understand that any violation may result in discipline.

I understand that Nevada law requires a registered dispensing technician who, in their professional or occupational capacity, knows or has reasonable cause to believe a child has been abused/neglected to report the abuse/neglect to an agency which provides child welfare services or to a local law enforcement agency, and make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the child has been abused/neglected. NRS 432B.220.

\_\_\_\_\_  
Applicant Print Name

\_\_\_\_\_  
Applicant Original Signature, no copies or stamps accepted

\_\_\_\_\_  
Date

**Board Use Only**

Date Received: \_\_\_\_\_

Amount: \_\_\_\_\_



# NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, Nevada 89521

(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444

• Web Page: [bop.nv.gov](http://bop.nv.gov)

**Applicant Name:** \_\_\_\_\_

**Payment:** Pay application fee by providing your credit or debit card information below, or by submitting a check made payable to **Nevada State Board of Pharmacy**.

**Credit Cards are charged a 5% processing fee**

<b>Credit Type:</b> <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express	<b>Credit Card #:</b> _____	
<b>Expiration Date:</b> ____/____(MM/YY)	<b>CVV (3 digits on back of card):</b> _____	<b>Registration Amount:</b> \$ _____
<b>Name on Card:</b> _____		
<b>Billing Address:</b> _____ _____ _____		