NEVADA STATE BOARD OF PHARMACY

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

Pharmaceutical Technician (PT) 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 "dispensing technician" at a dispensing practitioner's office, DO NOT COMPLETE THIS APPLICATION. Complete the "Dispensing Technician" application at www.bop.nv.gov.

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

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.

To register as a PT, you must meet one of the qualifications and provide the required documents as indicated below (NAC 639.240):

1. The successful completion of an ASHP-approved PT school or training program.
    a. Provide a copy of certificate of completion of the program.
2. **Active practice in good standing** in another state as a PT, and the successful completion of at least 1,500 hours of employment as a PT in a pharmacy in that state performing the duties set forth in paragraph (c) of subsection 3 of NRS 639.1371, which must be verified by a **signed affidavit** by the managing pharmacist of the pharmacy.
    a. Provide a copy of your PT registration, license, or certificate (if it is a requirement by that state to practice as a PT), which must be current, active, and in good standing.
    b. Provide the signed affidavit from your managing pharmacist that you have completed at least 1,500 hours of employment as a PT in a pharmacy in that state.
3. The successful completion of at least 1,500 hours of training and experience as a registered pharmaceutical technician in training (PTT), performing the duties set forth in paragraph (c) of subsection 3 of NRS 639.1371, in Nevada licensed pharmacies, which must be verified by the managing pharmacist of the pharmacy.
    a. Provide the signed form from your managing pharmacist that you have completed 1,500 hours of training and experience in a pharmacy in this state as a registered PTT.
4. The successful completion of a pharmaceutical technician training program conducted by a branch of the U.S. Armed Forces, the Indian Health Service of United States Department of Health and Human Services or the U.S. Department of Veterans Affairs.
    a. Provide a copy of certificate of completion of the program.

In addition to the requirements above, submit fingerprints for a background check by following the instructions at https://bop.nv.gov/uploadedFiles/bopnvgov/content/Services/newapps/FP%20Instructions%20NRS%20639.127%20639.1371.pdf. **ALL APPLICANTS MUST COMPLETE THIS SECTION. NRS 639.1371**

Please note:

- Applicants who do not qualify under one of the categories listed in NAC 639.240(2)(d) must apply as a pharmaceutical technician in training pursuant to NAC 639.242.
- Access Nevada Revised Statutes and Administrative Codes for pharmacy practice at www.bop.nv.gov.
- Every registered pharmaceutical technician shall, within 10 days after changing his or her residence or place of practice, give written notice of the change to the Board. NAC 639.225
- All PT 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.

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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: Program of Training for Pharmaceutical Technicians (Complete this section ONLY if you have successfully completed an ASHP and Board approved PT school or training program.)

Program/School Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Name of Program Director: _____

Section 3: Employment Information

Pharmacy Name: _____ License #: _____

Address: _____

City: _____ State: _____ Zip: _____

Section 4: Age and Education Requirements (You do not qualify to be a PT if you answer "NO" in this section.)	Yes	No
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: _____

Section 5: Military Service (NRS 622.120)	Yes	No
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: Federally Mandated Requirement (NRS 425.520, NRS 639.129)	Yes	No
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?		

Section 7: Personal and Professional History		
Before answering the questions below, please INITIAL to the right to attest you have read and understand the following: **WARNING** **You MUST provide truthful and complete responses to the questions on this application. If you omit information or provide false or misleading responses, including any failure to disclose past arrests or expunged convictions, this may be a basis for denial of your application and may result in disciplinary action against any other license or registration you hold from the Board.**	**Initials** _____	
	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 any 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 any state?		
4. Has your license/registration been subjected to any discipline for violation of pharmacy or drug laws in any 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 7 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

Section 8: You MUST submit the documents below with your application base on your qualifications as a PT.	
Select your qualification as a PT (please check a box).	**Required documents to be submitted with your application.**
☐ The successful completion of an ASHP-approved PT school or training program	a. Provide a copy of the certification of completion of the program.
☐ **Active practice in good standing** in another state as a PT, and the successful completion of at least 1,500 hours of employment as a PT in a pharmacy in that state performing the duties set forth in paragraph (c) of subsection 3 of NRS 639.1371, which must be verified by a **signed affidavit** by the managing pharmacist of the pharmacy.	a. Provide a copy of your PT registration, license, or certificate (if it is a requirement by that state to practice as a PT), which must be current, active, and in good standing. b. Provide the signed affidavit from your managing pharmacist that you have completed at least 1,500 hours of employment as a PT in a pharmacy **in that state** (see form provided in this application).
☐ The successful completion of at least 1,500 hours of training and experience as a registered pharmaceutical technician in training (PTT), performing the duties set forth in paragraph (c) of subsection 3 of NRS 639.1371, in Nevada licensed pharmacies, which must be verified by the managing pharmacist of the pharmacy.	a. Provide the signed form from your managing pharmacist that you have completed 1,500 hours of training and experience in a pharmacy **in this state** as a registered PTT (see form provided in this application).
☐ The successful completion of a pharmaceutical technician training program conducted by a branch of the U.S. Armed Forces, the Indian Health Service of United States Department of Health and Human Services or the U.S. Department of Veterans Affairs.	a. Provide a copy of the certification of completion of the program.

Section 9: Fingerprints for a background check. ALL APPLICANTS MUST COMPLETE THIS SECTION. NRS 639.1371

In addition to the requirements in section 7, submit fingerprints for a background check by following the instructions https://bop.nv.gov/uploadedFiles/bopnvgov/content/Services/newapps/FP%20Instructions%20NRS%20639.127%20639.1371.pdf

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 pharmaceutical 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.

_____

Print Name

_____ _____

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

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		
Credit Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express	**Credit Card #:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __	
Expiration Date: __ __/__ __ (MM/YY	**CVV** (3 digits on back of card): _____	**Registration Amount**: $_____
Name on Card: _____		
Billing Address: _____ _____ _____		

NEVADA STATE BOARD OF PHARMACY

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

Nevada Managing Pharmacist Certification of Training Hours for Pharmaceutical Technician in Training (PTT)

Rev (06/22/2022)

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

Section 1: Certification of PTT (NAC 639.242) MUST BE COMPLETED BY THE PHARMACY MANAGER

Name of PTT: _____ PTT License #: _____

Pharmacy Manager Name: _____ Pharmacy Manager License #: _____

Name of Pharmacy:_____ Pharmacy License #: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Time period PTT employed (mm/yy-mm/yy): _____

I certify to the Board that the above-named PTT has successfully completed _____ hours of training and experience performing the tasks of a PT listed in NRS 639.1371 (3)(c) and NAC 639.245(2). The specific training and experience completed is listed below:

Do you certify that the PTT is competent to perform the duties of a pharmaceutical technician? ☐Yes ☐No (If you answered "No" please explain why below):

I certify under penalty of perjury that the information contained on this form is accurate, true and complete in all material respects. I understand that making any false representation in this form is a crime under NRS 639.281. I understand that, pursuant to NRS 239.010, this form and any portion thereof is a public record unless otherwise declared confidential by law, and may be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020.

_____

Print Name (First, Last)

_____ _____

Original Signature of Managing Pharmacist, no copies or stamps accepted Date

Board Use Only	Date Received: _____

NEVADA STATE BOARD OF PHARMACY

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

Out-of-State Managing Pharmacist Certification of Employment Hours for Pharmaceutical Technician (PT)

Rev (06/22/2022)

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

Section 1: Certification of PT Employment Hours (NAC 639.240) MUST BE COMPLETED BY THE PHARMACY MANAGER

Name of PT: _____ PT License # (if applicable): _____

Pharmacy Manager Name: _____ Pharmacy Manager License #: _____

Name of Pharmacy:_____ Pharmacy License #: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Time period PT employed (mm/yy-mm/yy): _____

I certify to the Board that the above-named PT has successfully completed _____ hours of training and experience performing the tasks of a PT listed in NRS 639.1371 (3)(c) and NAC 639.245(2). The specific training and experience completed is listed below:

Do you certify that the PT is competent to perform the duties of a PT? ☐Yes ☐No
(If you answered "No" please explain why below):

I certify under penalty of perjury that the information contained on this form is accurate, true and complete in all material respects. I understand that making any false representation in this form is a crime under NRS 639.281. I understand that pursuant to NRS 239.010, this form and any portion thereof is a public record unless otherwise declared confidential by law, and may be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020.

_____
Print Name (First, Last)

_____ _____
Original Signature (electronic, copies or stamps not accepted) Date

Please have this section completed in the presence of a Notary Public.

State of _____, ss. County of _____

I, _____ (your name), am the _____ (your title) for _____ (name of Pharmacy), located at _____(address of Pharmacy). I have worked with the pharmaceutical technician, _____ (name of technician) listed on this form, and I certify that the statements contained herein are true and correct and contain a full and true account of the information requested.

_____ _____

Original Signature **Date**

Subscribed and Sworn to before me this _____ day of _____.

_____

Notary Public Signature

(Seal)

Board Use Only	Date Received: _____