



Louisiana Board of Pharmacy

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Application for Renewal of Pharmacy Technician Certificate for Year 2018 - 2019

Please complete, date and sign this application, then send it with any required attachments and the renewal fee, payable to "Louisiana Board of Pharmacy", to the address noted above, between May 1 and July 1, 2018. The total fee due with this application is **\$50**. An incomplete application, including one without the required attachments, will be returned to the applicant. Any renewal application hand-delivered, postmarked, or placed with a mail carrier on or after July 2, 2018 shall require a total fee of **\$75**. Applications received after July 30, 2018 shall be subject to additional reinstatement procedures and fees.

Section 1. Contact Information

Name: _____ Certificate No.: CPT. _____

Mailing Address: _____

City, State, ZIP: _____ Parish / County: _____

Telephone No: (Home) _____ (Mobile) _____

Email address: _____

** May be used for official communications. **

Section 2. Continuing Pharmacy Education (CPE) Requirement

Which of the following selections best describes your compliance with the Board's rules for continuing pharmacy education as a requirement for the renewal of a technician certificate?

- I earned at least 10 hours of technician specific ACPE-accredited or board-approved CPE between July 1, 2017 and June 30, 2018 – and all of my CE records are on file at CPE Monitor, where I have included my La. certificate number.
- I am exempt from the CPE requirements this year because I received my original technician certificate from the Louisiana Board of Pharmacy on or after July 1, 2017.
- None of the above.

Section 3. Survey

The Louisiana Legislature has directed the Workforce Commission to collect and compile information concerning the healthcare provider workforce supply and demand in the state. In cooperation with the Workforce Commission, we are obliged to collect certain information from you. You are required to answer these questions as part of your certificate renewal process. We appreciate your cooperation with this initiative.

1. On average, I practice pharmacy the following number of hours per week:

- | | |
|---|---|
| <input type="checkbox"/> Zero – not practicing pharmacy | <input type="checkbox"/> 31 to 40 hours |
| <input type="checkbox"/> 1 to 10 hours | <input type="checkbox"/> 41 to 50 hours |
| <input type="checkbox"/> 11 to 20 hours | <input type="checkbox"/> 51 to 60 hours |
| <input type="checkbox"/> 21 to 30 hours | <input type="checkbox"/> over 60 hours |

2. My primary professional practice setting is best described by which of the following selections:

- | | |
|---|--|
| <input type="checkbox"/> Community pharmacy – independent | <input type="checkbox"/> Consultant, in office-based practice |
| <input type="checkbox"/> Community pharmacy – chain | <input type="checkbox"/> HMO or other managed care organization |
| <input type="checkbox"/> Hospital or health-system pharmacy | <input type="checkbox"/> Mail service pharmacy |
| <input type="checkbox"/> Institutional pharmacy (other than hospital) | <input type="checkbox"/> Government owned healthcare facility |
| <input type="checkbox"/> Nuclear pharmacy | <input type="checkbox"/> Government, regulatory or law enforcement |
| <input type="checkbox"/> Academia (college of pharmacy) | <input type="checkbox"/> Other, not listed: _____ |
| <input type="checkbox"/> Home care | <input type="checkbox"/> Employed in another field OR unemployed |
| <input type="checkbox"/> Manufacture / Distribution (incl. sales) | |

3. In the event you are not practicing pharmacy, please indicate which of the following selections is most applicable to you:

- I am not practicing pharmacy, but I am seeking pharmacy employment.
- I am not practicing pharmacy, and I am not seeking pharmacy employment.
- I am retired from pharmacy practice.
- Not applicable to me, because I am employed in pharmacy practice.

4. In the event you are not practicing pharmacy, but you are employed in another capacity, which of the following selections best describes your employment:

- | | |
|--|---|
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Other medical field |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Other non-medical field |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Not applicable to me; I am retired or unemployed |
| <input type="checkbox"/> Physician | <input type="checkbox"/> Not applicable to me; I am practicing pharmacy |
| <input type="checkbox"/> Academia, unrelated to pharmacy | |

5. During Calendar Year 2017, I moved **TO** Louisiana from another state or other jurisdiction in order to seek or accept employment in pharmacy practice.

- Yes No

6. During Calendar Year 2017, I moved **FROM** Louisiana to another state or other jurisdiction in order to seek or accept employment in pharmacy practice.

- Yes No

Section 4. Disciplinary History

Since July 1 of last year (or at any time since your last renewal), have you been the subject of any of the following actions:

- Yes No A. Have you been issued a citation or summons, OR
has a warrant been issued against you, OR
have you been arrested, charged, arraigned, indicted, or convicted, OR
have you pled guilty, no contest, nolo contendere, or any similar plea, OR
have you been sentenced or pardoned
for any criminal offense, including all misdemeanors and felonies, in any local, state,
or federal jurisdiction?
NOTE: Traffic violations such as speeding or parking tickets do not need to be reported; however,
DUI or DWI events must be reported, regardless of final disposition.
- Yes No B. Have you had a professional license as a pharmacy technician or any other health
care provider denied, suspended, revoked, or otherwise sanctioned or restricted or
limited, including voluntary surrender of license and including restrictions associated
with participation in confidential alternatives to disciplinary programs, OR
Do you now have any disciplinary action pending against you by any state licensing
agency other than the Louisiana Board of Pharmacy?
- Yes No C. Have you been named as a defendant in a civil/malpractice case relating to your
practice of pharmacy, OR
Has a medical review panel opinion been rendered relating to your practice of
pharmacy, OR
Have you been reported to the National Practitioner Data Bank, OR
Have your clinical privileges been limited, restricted, suspended, or revoked?
- Yes No D. Have you been diagnosed with, or do you now have a medical, physical, mental,
emotional, or psychiatric condition that might affect your ability to safely practice as a
pharmacy technician?
- Yes No E. Have you been diagnosed with, or have you been treated for, or are you now
receiving treatment for, a dependency on mood-altering substances, drugs, or
alcohol?

[NOTE: Subject to the exemption noted in 4-A, an affirmative response to any question in this Section requires two attachments:
(1) a letter of explanation from you describing the incident in your own words, as well as (2) a certified copy of the disciplinary or
adverse action.]

Section 5. Attestations

1. I certify that I have acquired the amount and type of ACPE-accredited or board-approved continuing pharmacy education (CPE) as identified in the survey question above, and further, I have obtained an e-Profile number from the National Association of Boards of Pharmacy (NABP) CPE Monitor program, and all of my CE records are maintained at CPE Monitor. Further, I certify that I have granted permission to the Louisiana Board of Pharmacy to access and audit my CE records at CPE Monitor by recording my Louisiana license number at CPE Monitor.

Yes No

2. I certify that all of the answers provided to the survey questions and all of the information provided during this renewal process are true and accurate. Further, I understand and agree the provision of false information would result in the acquisition of a certificate by fraud or misrepresentation, which would provide a cause of action by the Board. Said action could result in the refusal to issue the renewal, or if already issued the suspension or revocation of my certificate.

Yes No

Signature: _____ **Date:** _____
Original required; no stamps or facsimile accepted