

MARYLAND STATE BOARD OF PHARMACY
4201 PATTERSON AVENUE
Baltimore, MD 21215-2299
Web site: **www.mdbop.org**

APPLICATION FOR PHARMACIST RECIPROCITY

For Board Use Only

Fee Paid _____ Date Licensed _____ License No. _____
Approved By: _____ Oral English Required _____
Qualified for: Reciprocity _____ No _____ Yes

Application Date: ____/____/_____
Date Expected to Begin Working in Maryland ____/____/_____

This application, with processing fee of \$120.00, must be submitted to: The Maryland Board of Pharmacy, 4201 Patterson Avenue, Baltimore, MD 21215.

To facilitate the processing of this application it is important that it be completely and correctly filled out with all of the necessary documents included.

First Name:		Middle or Maiden Name:		Last Name:	
Street Address:		City:		State:	Zip Code:
Tel Home: Tel Work:		Email Address:		Social Security Number:	
Place of Birth:		Date of Birth:	Age:	Sex:	Race:
Pharmacy School Name:			School Foreign Country:		
Address of Pharmacy School:		City:		State:	Zip Code:
Graduation Date:		Degree Rec.: Pharm D. ____ BS ____ Other: _____			
Have you ever taken an Oral English Competency Exam?		Type of Oral English Examination Taken:		Date Examination taken:	

FOREIGN GRADUSTES ONLY:

If applicant is a foreign graduate and has completed the Foreign Pharmacy Graduate Equivalency Examination (FPGEE), provide the EE number below. Please check that it is enclosed. If you have not completed the (FPGEE), you will be required to contact the NABP and complete the Foreign Pharmacy Graduate Equivalency Examination before becoming a licensed pharmacist in the State of Maryland.

Date of FPGEE Certificate _____ and EE# _____.

2. Pharmacist Licensure Information

Indicate licensure information about all current and previously held licenses to practice pharmacy. Include those held in a foreign country.

License Number & State or Country	Original License Date	License Expiration Date	Last Employer Name, City, State & Telephone Number

3. ALL APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS:

Please check Yes or No to the following:

A. Has any State Licensing or Disciplinary Board or comparable body in the Armed Service, denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, or revocation? **If yes, explain and attach a copy of the relevant document.**

YES _____ NO _____

B. Have you surrendered or failed to renew a license in any State? **If yes, provide the name of the State and the reason for this action.**

YES _____ NO _____

C. Are there any outstanding complaints, investigations or charges pending against you in any State by any Licensing or Disciplinary Board, or a comparable body in the Armed Services? **If yes, provide explanation.**

YES _____ NO _____

D. Have you ever been convicted of a felony or any violation (felony or misdemeanor) of any law relating to the practice of pharmacy in any state, country or other jurisdiction? **If yes, explain and attach a copy of the relevant document.**

YES _____ NO _____

E. Have you pled guilty, nolo contendere, or been convicted of a felony or a crime involving moral turpitude, or received probation before judgment of any criminal act? **If yes, explain and attach a copy of the relevant document.**

YES _____ NO _____

F. Have you pled guilty, nolo contendere, or been convicted of, or received probation before judgment of driving while intoxicated or of a controlled dangerous substance offense? **If yes, explain and attach a copy of the relevant document.**

YES _____ NO _____

G. Do you have a physical or mental illness or condition that may currently impair your ability to practice pharmacy? **If yes, please explain.**

YES _____ NO _____

H. Is your ability to practice pharmacy affected by an addiction to any type of drug or alcohol? **If yes, explain.**

YES _____ NO _____

4. I, _____ do solemnly swear or affirm, under the penalties of perjury, that I have personally completed this application, that the foregoing information is true, correct and complete to the best of my knowledge and belief, that I understand that violation will constitute grounds for revoking this license, and that I have read the Maryland Pharmacy Act, Health Occupations Article of the Annotated Code of Maryland and regulations promulgated by the Board and if licensed, agree to practice pharmacy in accordance with laws of Maryland.

Applicant's Full Signature & Date