Pharmacy Technician - Washington State Pharmacy Commission Approved Programs Application Packet

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Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. 42 U.S.C. § 666(a)(13); RCW 26.23.150. It will be used under the state's child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Please mail or email subsequent documents not sent with initial application to:

Pharmacy Technician Credentialing
PO Box 47877
Olympia, WA 98504-7877
Email: PQACpersonnelapplication@doh.wa.gov

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the correct required forms.

☐ **Application Fee**.
This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **Check if either apply:**
Request for Military Training and Experience Evaluation
Spouse or Registered Domestic Partner of Military Personnel

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form.

National Provider Identifier Number (NPI): The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10-digit numeric identifier. If you have a NPI number, provide this on your application.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: Legal name is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with Department of Health until we have been notified of a change. See **WAC 246-12-310**.

Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

Email: Enter your email address, if you have one. To expedite notice to the applicant, we will use the email address as the primary contact source to update the applicant on the status of their application. It is important to ensure the email address is correct and current at all times.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**
All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes all misdemeanors, gross misdemeanors, and felonies that you have ever had. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted a certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Verification of Education and Training:**

a. List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

b. Beginning with the most recent, list by location and type of work/experience all of your professional experience related to the practice of pharmacy/ pharmacy technician.

☐ **4. National Certification Exam:**
The Washington State Pharmacy Quality Assurance Commission requires all applicants to provide proof of passing a national pharmacy technician certification approved by the Commission. The Commission's approved examinations can be found it its policy statement on approved examination on this page.

Note: National Certification as a pharmacy technician is not a substitute for commission-approved training or training/education that is considered equivalent by the Commission.

☐ **5. Applicant's Attestation:**
You must sign and date this for us to process your application.

For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, do not qualify for license portability under the Servicemember Civil Relief Act, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited.

Documents to submit with your application should include the following:

- A copy of your spouse's or registered domestic partner's military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state's declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

For Current and Former Servicemembers Requesting Evaluation of Military Training and Experience

Under state law, your military education, training, and experience may count towards attaining certain civilian health care profession credentials in Washington State.

Submitted information will be reviewed by the Department of Health to determine substantial equivalency for meeting the credentialing requirements in this state.

Documents to submit with your health care professional credential application should include the following:

- If applicable, a copy of your DD214 Certificate of Release or Discharge from Active Duty, Member-4 or service 2 copy, or NGB-22 for National Guard.

  Please note:
  - A copy of your DD214 can be downloaded from the **EBenefits website**.
  - You can request a replacement copy of your NGB-22 on the **National Archives website**.
- Official Joint Service Transcript (JST) or Community College of the Air Force(CCAF) Transcripts.

  Please note:
  - JST can be sent electronically by visiting the **JST website** and selecting Washington State Department of Health.
  - CCAF transcripts cannot be sent electronically. See the **CCAF website** for transcript information.
- Verification of Military Experience and Training (VMET) or DD Form 2586. See the **DoDTAP website**.
- If applicable, application for the Evaluation of Learning Experiences During Military Service (DD Form 295). See the **Military Resources website**.

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Licensing Requirements

- Completed Application
- Non-refundable fees
- Director’s Certification Pharmacy Technician and Training Form
- National Certification Examination
- Verification of 8 hours of Law Study, or Certificate of Completion

National Certification Examination

The Washington State Pharmacy Quality Assurance Commission requires all applicants to provide proof of passing a national pharmacy technician exam approved by the Commission. The Commission’s approved examinations can be found in its policy statement on approved examinations on this page.

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Washington State Department of HEALTH

Date Stamp Here

Revenue: 0262010000

Pharmacy Technician Application
Washington State Pharmacy Commission Approved Programs

Please print clearly and complete all sections of the application. Follow all instructions provided. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

Select if either apply:
☐ Request for Military Training and Experience Evaluation
☐ Spouse or Registered Domestic Partner of Military Personnel

1. Demographic Information

Social Security Number (SSN) (If you do not have a SSN, see instructions)	**National Provider Identifier Number (NPI)** (Enter 10-digit number)	☐ Male ☐ Female ☐ Prefer not to answer ☐ X

Name First Middle Last

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County

Country

Phone (enter 10-digit #)	Fax (enter 10-digit #)	Cell (enter 10-digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ..... ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ..... ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ..... ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ..... ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you ever, at any age or time, been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended for any crime in any state or jurisdiction? **Please Note:** Failure to report criminal history will delay your application and may be considerered misrepresentation or fraud ..... ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential.

2. Personal Data Questions (cont.)

	Yes	No
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)?	☐	☐

3. Other License(s) and Professional Experience

3a. Other License, Certification, or Registration

List all states, US territories, or countries, where credentials are or were held. Attach additional pages if you need more space.

State/Jurisdiction	License/Certification/Registration Type	License/Certification/Registration		
		Issue Date	Expiration Date	Number

3b. Professional Experience

List in date order, most recent to later, all your professional experience. Attach additional pages if you need more space.

Name, address and phone number of employer	Nature of experience	Start (mm/yyyy)	End (mm/yyyy)

4. National Certification Exam

Name of Exam_____ Date Taken _____

Certification Number _____

If different, list your name at the time the exam was taken: _____

5. Applicant's Attestation

I, _____, declare under penalty of perjury under the
(Print applicant name clearly)

laws of the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.
- I am 18 years of age or older.
- I have a high school diploma or GED.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated_____ By: _____
(mm/dd/yyyy) (Original signature of applicant)

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Pharmacy Technician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Director's Certification
Pharmacy Technician Education and Training

This form is used to report education and training received through a Pharmacy Quality Assurance Commission approved Technician Training Program.

The Director's Certification form **must be** completed and signed by the training program director as identified and on file with the Department of Health, Pharmacy Quality Assurance Commission. Any sections left blank will result in an incomplete or deficient application.

I declare under penalty of perjury under the laws of the state of Washington the following is true and correct:

I attest that the applicant has successfully completed the Pharmacy Quality Assurance Commission approved program of study and training to become a pharmacy technician.

I attest that the program consisted of the required instructional and supervised practical hours required; not to exceed 12 months. The program included at a minimum the following topics:

1. Legal aspects of pharmacy practice such as law and rules governing practice.
2. Hygiene/aseptic techniques and safety considerations.
3. Terminology, abbreviations and symbols.
4. Components of a prescription and patient medication record.
5. Drug dosage forms, routes of administration and drug product packaging, weighing and measuring, packaging and labeling, drug nomenclature, drug standards and information sources.
6. Pharmaceutical calculations.
7. Identification of drugs by trade and generic names, and therapeutic classifications.
8. Ordering, restocking, and maintaining drug inventory.
9. Computer applications in the pharmacy.
10. Communication techniques and confidentiality of information.

Applicant's Name:	Applicant's Date of Birth:	
Dates of instructional and supervised practical training as a pharmacy technician: Start Date (MM/DD/YYYY): Completion Date: (MM/DD/YYYY):		
Is this pharmacy technician training program credentialed or approved by the Pharmacy Quality Assurance Commission? ☐ No ☐ Yes Credential number _____		
Training Program or Pharmacy Name:	Pharmacy License Number (if applicable):	
Address:	Telephone Number:	
City	State	Zip Code
Director's Name (printed):	Director's License Number(s):	
Director's Email:	Director's Phone Number:	
Director's Signature:	Date (mm/dd/yyyy):	

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Pharmacy Technician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Law Study Verification

Applicant's Name: _____ Date of Birth: _____

Has completed a minimum of eight hours of study and discussion of Washington State pharmacy law under my supervision and possesses a working knowledge of this law.

Pharmacist information:

Printed name:
Signature:
WA State License number:

Pharmacist contact information:

Name:
Street:
City:
Phone (enter 10-digit #):
Today's Date:
Email Address:

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RCW/WAC and Online Website Links

RCW/WAC Links

Uniform Disciplinary Act, RCW 18.130

Administrative Procedure Act, RCW 34.05

Administrative Procedures and Requirements, WAC 246-12

Pharmacy Technician Laws, RCW 18.64A

Pharmacy Technician Rules, WAC 246-945

Online

Pharmacy Quality Assurance Commission, Website