Pharmacist License by Exam for Foreign Graduates
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. Please call the Customer Service Center at 360-236-4700 if you have questions.

In order to process your request:

Mail your application with initial
documentation and your check
or money order payable to:
Department of Health
P.O. Box 1099
Olympia, WA  98507-1099

Send other documents not sent
with initial application to:
Pharmacy Quality Assurance
Commission Credentialing
P.O. Box 47877
Olympia, WA  98504-7877

Contact us:
360-236-4700

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 civil.rights@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 required forms.

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

☐ Select if the following applies:
  - 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 or obtain a license from the Department of Health. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you do not have one.
  - 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 the 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 misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. 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 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. Other License, Certification, or Registration:
List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the Verification Form and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

4. Education and Training:
List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

5. Experience:
List in date order, most recent to later, all your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.

6. Applicant’s Attestation:
You must sign and date this for us to process the 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 service member of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.
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.
License Requirements

This is information to apply for a Pharmacist License by exam for Foreign Graduates. For more information visit our website.

Note: All non-English documents must be translated before sending copies to the commission.

General Information

1. If your academic training in pharmacy is from a foreign country, you must take and pass the Foreign Pharmacy Graduate Equivalency Examination (FPGEE) and provide an education equivalency certification from the Foreign Pharmacy Graduate Education Commission (FPGEC). If you do not have your FPGEE score sheet and FPGEC certification, to begin the FPGEC application process, contact the National Association of Boards of Pharmacy (NABP) at https://nabp.pharmacy/. When you have completed all of the necessary requirements, NABP will advise you to register for the FPGEE and TOEFL iBT (English language proficiency exam).

2. Washington State uses the North American Pharmacist License Exam (NAPLEX) to test your knowledge, judgment and skills as an entry-level pharmacist. Multistate Pharmacy Jurisprudence Examination (MPJE) tests you on both federal, state laws, and rules.

3. The Pre-NAPLEX practice examination is available on the NABP website at https://nabp.pharmacy/.

4. You must submit a computerized exam registration form for both the NAPLEX and MPJE at https://nabp.pharmacy/ or mail it to 1600 Feehanville, MT. Prospect IL 60056. You may complete the registration forms and submit the payment by credit card, VISA or Master Card, at the NABP Website.

5. To receive your Authorization to Test (ATT):
   • Register with and pay exam fees to the NABP.
   • Submit all required documentation before testing to our office. Once the above steps have been completed, Washington State Pharmacy Quality Assurance Commission will then release your name to the NABP as “ready to test”. The NABP will send your ATT.
   • Score results are typically available approximately seven days after you have taken the examination and will be available on your NABP e-Profile.

6. Reporting internship hours: Qualifying internship hours must be earned under the personal supervision of a licensed pharmacist, in a licensed pharmacy in the United States. The pharmacist’s license must be active and in good standing. Use the Supervising Pharmacist Evaluation and Certification of Experience and Intern Site Evaluation forms to report these hours to the Washington State Pharmacy Quality Assurance Commission for each location.
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Requirements Checklist

This is information to apply for a pharmacist license by exam for foreign graduates.

Note: Use this checklist as a tool to track information as you send items to the commission.

Name _______________________________________________________________________

Address _____________________________________________________________________

City ___________________________ State _________ Zip Code ______________

Items required before intern registration:

_________ Copy of your FPGEE score report.

_________ Copy of your FPGEC certificate.

_________ State intern application with the nonrefundable fee. See online fee page.

_________ Email from NABP verifying FPGEC certificate. This is done by Pharmacy Quality Assurance Commission.

Items required before taking the NAPLEX and MPJE:

_________ State pharmacist application with the nonrefundable fee. See online fee page.

_________ Official transcripts or copy of your diploma from pharmacy school.

_________ Certification of a minimum fifteen hundred pharmacy internship hours.

_________ Supervising Pharmacist's Evaluation.

_________ Intern site evaluation.

Required before pharmacist license:

_________ NAPLEX score, on _____________________ you received a score of _________.

_________ MPJE score, on _____________________ you received a score of _________.
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**Pharmacy Intern Registration Application**

Please print clearly. Follow the instructions as 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.

**Applying For (mark only one):**
- [ ] ACPE Graduate
- [ ] Graduate of school outside US
- [ ] Current ACPE Pharmacist Student  School Name ___________________________  Enrollment Date ______________________
- [ ] Out of State Pharmacist enrolled in Residency Program  [ ] Commission Requires Additional Practical Experience

**Select if the following applies:**  [ ] Spouse or Registered Domestic Partner of Military Personnel

### 1. Demographic Information

<table>
<thead>
<tr>
<th>Social Security Number (SSN) (If you do not have a SSN, see instructions)</th>
<th>National Provider Identifier Number (NPI) (Enter 10 digit number)</th>
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<tr>
<td>Name</td>
<td>First Middle Last</td>
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- [ ] Male
- [ ] Female
- [ ] Prefer not to answer
- [ ] X

- 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):
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 been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? □ □

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. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.
2. Personal Data Questions (cont.)

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 (DHS)? ☐ ☐

3. Other License, Certification, or Registration

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

<table>
<thead>
<tr>
<th>State/Jurisdiction</th>
<th>License/Certification/Registration Type</th>
<th>License/Certification/Registration Year Issued</th>
<th>License/Certification/Registration Number</th>
<th>Method of Licensure</th>
<th>Exam</th>
<th>Endorse</th>
<th>Grand Fathered</th>
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</table>
### 4. Education and Training

List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

<table>
<thead>
<tr>
<th>Full Name, City and State/Schools Attended</th>
<th>Degree Earned</th>
<th>Attendance</th>
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### 5. Experience

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

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<thead>
<tr>
<th>Name and Location of Institution</th>
<th>From (mm/yyyy)</th>
<th>To (mm/yyyy)</th>
<th>Type of Experience or Speciality</th>
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6. Applicant’s Attestation

I, _________________________________, declare under penalty of perjury under the laws of the state of
Washington that 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 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 that 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 that 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)
# Pharmacist License Application

**Please check the appropriate box:**

- [ ] By Exam (NAPLEX) for New Graduates
- [ ] By Exam (NAPLEX) for Foreign Graduates
- [ ] By License Transfer/Reciprocity
- [ ] By Score Transfer for U.S. Graduates
- [ ] By Score Transfer for Foreign Graduates

**Select if the following applies:**

- [ ] Spouse or Registered Domestic Partner of Military Personnel

## 1. Demographic Information

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<tr>
<th>Social Security Number (SSN) (If you do not have a SSN, see instructions)</th>
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</thead>
<tbody>
<tr>
<td>Name First Middle Last</td>
<td>Male</td>
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</tbody>
</table>

**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**

<table>
<thead>
<tr>
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<th>Yes</th>
<th>No</th>
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<tr>
<td>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.</td>
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<td>“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.</td>
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<td>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.</td>
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<td>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.</td>
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<td>“Currently” means within the past two years. “Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.</td>
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<td>5. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction?</td>
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<td><em>Note:</em> 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. To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.</td>
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Page 2 of 5
2. Personal Data Questions (cont.)

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
doctors 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, Certification, or Registration

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

<table>
<thead>
<tr>
<th>State/Jurisdiction</th>
<th>License/Certification/Registration</th>
<th>Method Licensed</th>
<th>License/Certification/Registration</th>
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<td>Type</td>
<td>Exam</td>
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### 4. Education and Training

List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

<table>
<thead>
<tr>
<th>Graduate School</th>
<th>Degree and Major</th>
<th>start (mm/yyyy)</th>
<th>end (mm/yyyy)</th>
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### 5. Professional Experience

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

<table>
<thead>
<tr>
<th>Name and location of institution</th>
<th>Type of experience</th>
<th>start (mm/yyyy)</th>
<th>end (mm/yyyy)</th>
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6. Applicant’s Attestation

I, ________________________________, declare under penalty of perjury under the 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 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 that 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)
(This page intentionally left blank.)
# Intern Site Evaluation Report

Note: This form must be submitted to the commission office upon completion of an internship experience. No internship hours will be accepted without this evaluation report pursuant to [WAC 246-945-163](https://app.leg.wa.gov/statute/cascade.do?source=statutes&title=246&chapter=945&section=163). If the internship experience exceeds twelve months, it is recommended that this form be submitted annually.

<table>
<thead>
<tr>
<th>Name of Intern:</th>
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<tbody>
<tr>
<td>Credential Number:</td>
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<table>
<thead>
<tr>
<th>Name of Supervising Pharmacist:</th>
<th>Credential Number:</th>
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<tbody>
<tr>
<td>Name of Internship Site:</td>
<td>License Number:</td>
</tr>
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<table>
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<tr>
<th>Street Address</th>
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<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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Intern evaluation of supervising pharmacist:

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Intern evaluation of internship program at this site:

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Signature of Intern | Date:
|-------------------|---|
Supervising Pharmacist Evaluation of Intern

This form must be submitted to the commission at the completion of the internship experience. If the internship experience exceeds twelve months, it is recommended that this form be filed annually.

Name of Intern

Credential Number

Name of Supervising Pharmacist

Credential Number

Name of Internship Site

License Number

Street Address

City

State

Zip Code

Signature of Supervising Pharmacist

Date

Supervising Pharmacist’s Evaluation & Certification of Experience

Briefly describe the type of professional experience received under your supervision. Comment on the intern’s communication skills, accuracy, professional attitude, dispensing skills, ability to evaluate and monitor therapy, and knowledge of pharmacy management. Also, pursuant to WAC 246-945-163, provide your assessment of the intern’s ability to practice pharmacy at this stage of his or her internship. Attach additional completes pages if you need more space.

Signature of Supervising Pharmacist

Date
<table>
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<tr>
<th>From (Sunday) MM/DD/YY</th>
<th>To (Saturday) MM/DD/YY</th>
<th>Hours</th>
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**For the Two-Week Period of**

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<th>To (Saturday) MM/DD/YY</th>
<th>Hours</th>
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Total internship hours __________________________

Note: Internship hours will not be accepted after the signature date.

**Pharmacist Certification of Experience**

I certify that the intern completed the hours recorded here and the record is correct, to the best of my knowledge. The experience gained by the intern has been related to the practice of pharmacy as required by law.

________________________________________  __________________  ___________________________
Pharmacist’s signature                  Date          Credential number
RCW/WAC and Online Website Links

**RCW/WAC Links**

*Uniform Disciplinary Act, 18.130 RCW*

*Administrative Procedure Act, 34.05 RCW*

*Administrative Procedures and Requirements, 246-12 WAC*

*Pharmacy Laws, 18.64 WAC*

*Pharmacy Rules, 246-945 WAC*

**Online**

*Pharmacy Quality Assurance Commission, Web Page*