



FLORIDA BOARD OF PHARMACY
P.O. Box 6320 • Tallahassee, FL 32314-6320
Phone: (850) 245-4292 www.doh.state.fl.us/mqa/pharmacy

CONFIDENTIAL AND EXEMPT FROM PUBLIC RECORDS DISCLOSURE

Name: _____
 Last **First** **Middle**

Social Security Number: _____

This page is exempt from public records disclosure. The Department of Health is required and authorized to collect Social Security Numbers relating to applications for professional licensure pursuant to Title 42 USCS § 666 (a)(13). For all professions regulated under chapter 456, Florida Statutes, the collection of Social Security Numbers is required by section 456.013 (1)(a), Florida Statutes.

Please attach a 2x2 photo here

(Please do not staple photo to application)



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ITEM #2 - INTERN APPLICATION

Rule 64B16-26.400(1), Florida Administrative Code, states, "No person may serve as a pharmacy intern in a pharmacy in this state until such time as he/she is registered with the Department of Health as an intern." Intern certificates issued by the Florida Board of Pharmacy (the board) are valid for the State of Florida ONLY and must be returned to the board after an intern has become a Registered Pharmacist in the State of Florida. Applicants must complete the information below and forward the application to the College of Pharmacy to be completed by the Dean and returned to the address above.

Please print or type legibly.

1. Biographical Information				
Last Name		First Name		Middle Name
Home Address (Mailing Address – ML)		City	State	Zip
Work Address (Practice Location – PL)		City	State	Zip
Current Phone Number	Home Phone Number		Date of Birth	
2. Equal Opportunity Data – We are required to ask that you furnish the following information as part of your voluntary compliance with Section 2, Uniform Guidelines on Employee Selection Procedure (1978) 43FR38295 (August 25, 1978). The information is gathered for statistical and reporting purposes only and does not in any way affect your candidacy for licensure. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female RACE: <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Other				
3. If known, indicate the name and address of the pharmacy where you will intern in Florida.				
4. Have you ever applied to take the Florida pharmacist examination? If yes, please indicate the date.				
Yes _____ No _____ Date _____				
5. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest, to a crime in any jurisdiction other than a minor traffic offense?				
Yes _____ No _____ <small>(You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction. Driving under the influence or driving while impaired is <u>NOT</u> a minor traffic offense for the purposes of this question.)</small>				
6. In the last five (5) years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?				
Yes _____ No _____				
7. In the last five (5) years, have you been admitted or referred to a hospital, facility or impaired				

practitioner program for treatment of a diagnosed mental disorder or impairment?	
Yes _____	No _____
8. During the last five (5) years, have you been treated for or had a recurrence of a diagnosed physical impairment that has impaired your ability to practice pharmacy?	
Yes _____	No _____
9. In the last five (5) years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five (5) years?	
Yes _____	No _____
10. Has disciplinary action ever been taken against your pharmacist or any other professional license in this state or any other state?	
Yes _____	No _____
11. Have you ever surrendered your pharmacist or any other professional license in another jurisdiction when disciplinary action was pending?	
Yes _____	No _____
12. Are you presently being investigated or is any disciplinary action pending against you?	
Yes _____	No _____
All of the above questions must be answered or your application will be returned for completion. If you answer "yes" to any of the questions in 5-12, attach a statement giving full details, and submit a certified official copy of the order of the court or state board of pharmacy.	

_____ (SIGNATURE OF APPLICANT) _____ (DATE)

12. TO BE COMPLETED BY DEAN OF COLLEGE OF PHARMACY

This is to certify that the above named applicant is entered into the professional curriculum of the _____, as of _____; and is a graduate
 (NAME OF SCHOOL) (DATE)
 of said professional curriculum as of _____.
 (DATE)

 (PRINT NAME OF DEAN)

 (SIGNATURE OF DEAN)

 (DATE)

(SCHOOL SEAL)