PTN-01, Rev 09/09

STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
DRUG CONTROL DIVISION
Telephone: (860) 713-6065
Email: drug.control@ct.gov
Web Site: www.ct.gov/dcp

For Official Use Only

PHARMACY TECHNICIAN APPLICATION

INSTRUCTIONS:
All spaces must be completed - please print or type. This application **must be accompanied by a check or money order in the amount of $100.00.** made payable to ***"Treasurer, State of Connecticut"*.** Application fees are non-refundable**.** Registrations are non-transferable. Annual Expiration March 31st.

➔ Return your completed application and fee to:
Department of Consumer Protection, License Services Division, 165 Capitol Avenue, Hartford, CT 06106

Please check (✓) preferred address for mailing: ☐ **Residence** ☐ **Pharmacy**

First Name	Middle Initial	Last Name	☐ Male ☐ Female
Residence Street Address		City	State	Zip Code
Telephone Number (w/ area code)	Email Address	Social Security Number	Date of Birth
Name of Licensed Pharmacy/Institution where Employed			CT Pharmacy License Number
Pharmacy Street Address		City	State	Zip Code

Have you previously been employed as a Pharmacy Technician continuously for the past three (3) years? ☐ Yes ☐ No If yes, please provide your CT Pharmacy Technician Registration Number.

Has the applicant ever been convicted of a felony? ☐ Yes ☐ No If yes, please attach a statement indicating the type(s) of crime(s) for which you were convicted, the date(s) and court(s) where the conviction(s) occurred and a description of the circumstances.

The Commission of Pharmacy must be informed of any changes in name or home address within five (5) days of such change

To be completed by Pharmacist Manager of Licensed or Institutional Pharmacy

This is to certify that _____ has been hired as a pharmacy technician and has commenced, is in the process of, or has completed pharmacy technician training in accordance with Connecticut General Statutes Section 20-598a.

_____
Pharmacist Manager/Director License Number

Certified By: _____ _____
Print Name of Pharmacist Manager/Director Signature of Pharmacist Manager/Director

I have read the above statement and it is true to the best of my knowledge. I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Commissioner of Consumer Protection or any person designated by the commissioner in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes.

_____ _____
Signature of Pharmacy Technician Applicant Date