



ARIZONA STATE BOARD OF PHARMACY
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www.azpharmacy.gov

FOR AGENCY USE ONLY

ASBP Approval:		License No.:		Fee:		Receipt No.:	
Effective Date:		Certificate Mailed:		Check No.:		Check Date:	
Fee From:		Fee To:					

APPLICATION FOR LICENSURE AS AN ARIZONA PHARMACY TECHNICIAN

- ☐ **Pharmacy Technician** (prorated fee [contact Board Office for amount], copy of U.S. birth certificate, and copy of PTCB certificate)
- ☐ **Pharmacy Technician Trainee** (\$46.00, copy of U.S. birth certificate, and copy of high school diploma)
- ☐ **Pharmacy Technician Trainee Reapply** (\$36.00, letter stating reason for reapply request)

Name:	(First)	(Middle)	(Last)		
	(Phone)	(SSN)	(Email)		
Address:	(Street and Number)	(City)	(County)	(State)	(Zip)
Mailing Address: (if different)	(Street and Number)	(City)	(County)	(State)	(Zip)
Birth Information:	(City)	(State)	(Country)	(Date of Birth)	
Employment site:					
Address:	(Street and Number)	(City)	(County)	(State)	(Zip)

Has the applicant had any convictions involving a misdemeanor, felony offenses or any drug-related offenses?

NOTE: Even though a conviction has been vacated, pardoned, expunged, dismissed or appealed or your civil rights restored, you are required to answer "YES."

☐ **YES**

☐ **NO**

If "YES," please provide the following information: charge(s), conviction date(s), name of sentencing court(s), court's location, and final disposition of the charge(s) or conviction(s) by attaching the information to this application.

Has the applicant ever been licensed as a pharmacy technician or held any other professional or occupational license?

☐ **YES**

☐ **NO**

If "YES," please provide the following information: date of original licensure and renewal(s), where licensed and current licensure status (e.g., active, inactive, revoked, suspended, probation, reprimand, any pending disciplinary action against the license(s)) by attaching the information to this application.

Has any jurisdiction denied the applicant a pharmacy technician license or any other professional or occupational license?

☐ **YES**

☐ **NO**

If "YES," please provide the following information: state(s) where denied, when denied and reason(s) the state(s) denied your licensure application(s) by attaching the information to this application.

To the best of my knowledge and belief the foregoing application is true and current in all respects. False reporting can result in denial or loss of license.

Signature: _____ Date: _____

Title II of the Americans with Disabilities ACT prohibits the Arizona State Board of Pharmacy from discriminating on the basis of disability. This material is available in an alternate format upon request.