Pharmacy Technician Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360-236-4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

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

Send other documents not sent with initial application to:

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

Contact us:

360-236-4700

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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.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. 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.

Birth place: Provide the city, state and country where you were born.

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 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.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content is found in **WAC 246-12-270**.

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

a. Indicate the process you will use to verify your education and training by checking the applicable box and attaching required documentation.

b. List by state, type and effective dates all health care related licenses, certifications or registrations you hold or have held. An Out-of-State verification form is enclosed and must be sent to each state you listed. Enter your full name and birth date at the top of the form so the state can identify you. Also contact each state listed for any fees they may charge for processing the verification.

c. 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.

☐ **5. National Certification Exam:**
Attach a copy of the certification or proof of passing a pharmacy technician certification exam administered by a National Commission for Certifying Agencies (NCCA) accredited organization/program.

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

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at the **military resources page** and include supporting documentation with your application.

Instructions for Current and Former Servicemembers Requesting Evaluation of Military Training and Experience Toward Meeting Washington Credentialing Requirements

The Department of Health licenses health care professionals in accordance with state laws and requirements. Under a new state law passed in 2011, people with military training and experience may count their training and experience towards certain civilian health care profession credentialing requirements if the state determines it is substantially equivalent to the state's standards.

Please complete the additional form found at the **military resources page** and include supporting documentation with your application.

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Licensing Requirements

- Completed Application
- Nonrefundable fees
- Verification of Education and Training
- National Certification Examination

National Certification Examination

All applicants must provide verification of successful completion of a commission-approved program or seek commission approval of training acquired in another state or country. The Washington Pharmacy Commission requires all applicants to provide proof of passing a national pharmacy technician certification examination administered by a program accredited by the National Commission for Certifying Agencies (NCCA). Information on approved exams can be found by visiting the **Institute for Credentialing Excellence**.

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.

Applicants who Have Completed Pharmacy Quality Assurance Commission Approved Pharmacy Technician Program

All training programs must include educational as well as experiential training.

You must submit the following:

- Instructional and Practical/Experiential Training
  - Director's Certification of Pharmacy Technician Education and Training Form
- Legal Aspects of Pharmacy Practice
  - Affidavit of eight hours Washington State pharmacy law study. The verification of law study form must be signed by a pharmacist currently licensed to practice in Washington State.
- Copy of National Certification Examination Certificate or Official Score Report.

There are hospitals and retail pharmacies throughout the state with approved programs. The director of the approved program must complete the director's certification to verify successful completion of the on-the-job (OJT) training or formal academic program.

The following retailers have training programs that are approved nationally or for multiple states.

- Fred Meyer (WA, OR, AK, and ID)
- Rite Aid
- Safeway
- Sav-on (Albertsons)
- Walgreens
- Wal-Mart

Applicants who Have Completed an Out-of-State Pharmacy Technician Program

Training received in another state must meet the same basic criteria as a Washington Commission-approved program. All training programs must include educational as well as experiential training.

In order to have your out-of-state on-the-job (OJT) or academic program approved, you will need to submit a request for an evaluation of your training program. Your request for approval of your training must be accompanied by a completed pharmacy technician application.

Formal/Academic Training Program

- Instructional and Practical/Experiential Training:
  * Copy of official transcripts showing a diploma or certificate earned for Pharmacy Technician; and School catalog describing the coursework; **OR**
  * Copy of official transcripts showing a diploma or certificate earned for Pharmacy Technician; and the signed Affidavit of Formal/Academic Technician Education and Training

AND

- Verification of current active pharmacy practice (mark form with n/a if not applicable)
- Legal Aspects of Pharmacy Practice
  * Affidavit of eight hours Washington State pharmacy law study. The verification of law study form must be signed by a pharmacist currently licensed to practice in Washington State.
- Copy of National Certification Examination Certificate or Official Score Report.

Note: Official transcript must be sent from your school directly to:
Pharmacy Technician Credentialing
PO Box 47877
Olympia WA 98504-7877

Out-of-State Pharmacy On-the-Job Pharmacy Technician Training Program

- Instructional and Practical/Experiential Training (all items required)
  * Affidavit of on-the-job Pharmacy Technician Education and Training
  * Training course outline
  * Letter of Recommendation
  * Verification of current active pharmacy practice (mark form with n/a if not applicable).

AND

- Legal Aspects of Pharmacy Practice
  * Affidavit of eight hours Washington State pharmacy law study. The verification of law study form must be signed by a pharmacist currently licensed to practice in Washington State.
- Copy of National Certification Examination Certificate or Official Score Report.

Military Trained Pharmacy Technicians

The Washington State Pharmacy Commission accepts pharmacy technician training received through any branch of the U.S. Armed Forces.

- A copy of your diploma or DD 214 form.
- Affidavit of eight hours Washington State pharmacy law study. The verification of law study form must be signed by a pharmacist currently licensed to practice in Washington State.
- National Certification Examination Certificate or Card

Foreign Trained Pharmacist or Medical School Degree Graduates

- Educational Training
  * Copy of a certified translation of official transcript and diploma.
  * Proof of passing Test of English as a Foreign Language (iBT).

AND

- Practical/Experiential Training
  * 520 hours of supervised experience in a Washington State approved technician training program.

AND

- Legal Aspects of Pharmacy Practice
  * Affidavit of 8 hours Washington State pharmacy law study. The verification of law study form must be signed by a pharmacist currently licensed to practice in Washington State.
- Test of English as a Foreign Language
  * Foreign trained pharmacy technicians where English is not the primary language must pass the TOEFL iBT. The TOEFL iBT is the sole English language proficiency examination accepted.

    TOEFL iBT - minimum passing scores
    - Reading: 21
    - Listening: 18
    - Speaking: 26
    - Writing: 24

- Copy of National Certification Examination Certificate or Official Score Report.

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Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0262010000

Pharmacy Technician Application

Please print clearly. 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.

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

Name First Middle Last

Birth date (mm/dd/yyyy)	**Place of birth**		
	City	State	Country

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 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.**
>
> **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.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction? ..... ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ..... ☐ ☐

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. AIDS Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand if I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

4. Verification of Education and Training

4a. Indicate below the process used to verify pharmacy technician education and training and include required documentation as described in the License Requirements form.

Check only one:

- ☐ Completed a Washington State Commission-approved Pharmacy Technician Training Program
- ☐ Completed an Out-of-state On-the-job Pharmacy Technician Training Program
- ☐ Completed an Out-of-state Formal or Academic Pharmacy Technician Training Program
- ☐ Graduate of a foreign pharmacy or medical school degree program or foreign trained Pharmacy Technician Program

4b. Other License, Certification, or Registration

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

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

4c. Professional Experience

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

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

5. National Certification Exam

Name of Exam_____ Date Taken _____

Certification Number _____

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

6. 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 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 _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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Washington State Department of Health
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.

Note: The designated program director must sign the certification.

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:	
Dates of instructional and supervised practical training as a pharmacy technician: Start Date: Completion Date:	
Is this pharmacy technician training program credentialed or approved by the Pharmacy Quality Assurance Commission? ☐ No ☐ Yes Credential/Approval number _____ (enter n/a if this does not apply)	
Training Program or Pharmacy Name:	License Number (if applicable):
Address:	Telephone Number:
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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Washington State Department of Health
Pharmacy Technician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Affidavit of An Out of State Formal Academic Pharmacy Technician Education and Training Program

This form is used to report education and training received outside of **Washington State**. It may not be used to report education and training received in Washington State.

The Affidavit of An Out of State Formal Academic Education and Training Program form must be accompanied by official transcripts showing a diploma earned and extern hours completed for pharmacy technician. The form must be completed by an official representative of the formal education program. Any sections left blank will result in an incomplete or deficient application.

Official Representative or Registrar'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 that oversees the pharmacy technician training program.
- I personally supervised or have knowledge of the applicant's successful completion of a program of education and training for pharmacy technician in the pharmacy identified below and licensed by the state of_____.
- I attest that the training program completed by the applicant included a total of _____ hours of classroom instruction.
- I attest that the training program completed by the applicant included a total of _____ hours of experiential/practical training.
- I attest that the technician training program included at a minimum the following topics of instructions and practical training:

☐ Legal aspects of pharmacy practice such as law and rules governing practice.

☐ Hygiene/aseptic techniques and safety considerations.

☐ Terminology, abbreviations and symbols.

☐ Components of a prescription and patient medication record.

☐ Drug dosage forms, routes of administration and drug product packaging, weighing and measuring, packaging and labeling, drug nomenclature, drug standards and information sources.

☐ Pharmaceutical calculations.

☐ Identification of drugs by trade and generic names, and therapeutic classifications.

☐ Ordering, restocking, and maintaining drug inventory.

☐ Computer applications in the pharmacy.

☐ Communication techniques and confidentiality of information.

I attest that the program of instructional and supervised practical training is outlined in the attached written plan that shall be available to the Pharmacy Quality Assurance Commission upon request.

Applicant's Name:	
Dates of instructional and supervised practical training as a pharmacy technician: Start Date: Completion Date:	
Is this pharmacy technician training program credentialed or approved by the Pharmacy Quality Assurance Commission? ☐ No ☐ Yes Credential/Approval number _____ (enter n/a if this does not apply)	
Name of School:	
Address of School:	
Official Program Representative (print name):	Official Program Representative (print title):
Official Program Representative Email Address:	Telephone Number:
Signature of Official Program Representative:	Date (mm/dd/yyyy):

Washington State Department of Health
Pharmacy Technician
Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Affidavit of An Out of State On-the-Job Pharmacy Technician Education and Training

This form is used to report education and training received outside of Washington State. It may not be used to report education and training received in Washington State or outside of the United States.

Note: The affidavit of An Out of State On the Job Education and Training Program form must be accompanied by the program course outline. The form must be completed by the supervising pharmacist. Any sections left blank or omission of course outline will result in an incomplete or deficient application.

Supervising Pharmacist's Attestation

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

- Attached is a true and accurate course outline of the training received by the applicant identified below.
- I am the person that oversees the pharmacy technician training program.
- I personally supervised or have knowledge of the applicant's successful completion of a program of education and training for pharmacy technician in the pharmacy identified below and licensed by the state of _____.
- I attest that the training program completed by the applicant included a total of _____ hours of instruction including didactic and practical training.
- I attest that the technician training program included at a minimum the following topics of instruction and practical training:

☐ Legal aspects of pharmacy practice such as law and rules governing practice.

☐ Hygiene/aseptic techniques and safety considerations.

☐ Terminology, abbreviations and symbols.

☐ Components of a prescription and patient medication record.

☐ Drug dosage forms, routes of administration and drug product packaging, weighing and measuring, packaging and labeling, drug nomenclature, drug standards and information sources.

☐ Pharmaceutical calculations.

☐ Identification of drugs by trade and generic names, and therapeutic classifications.

☐ Ordering, restocking, and maintaining drug inventory.

☐ Computer applications in the pharmacy.

☐ Communication techniques and confidentiality of information.

I attest that the program of instructional and supervised practical training is outlined in a written plan that shall be available to the Pharmacy Quality Assurance Commission upon request.

Applicant's Name:	
Dates in which instructional and supervised practical training was received: Start Date: Completion Date:	
Is this pharmacy technician training program credentialed or approved by the Pharmacy Quality Assurance Commission? ☐ No ☐ Yes Credential/Approval number _____ (enter n/a if this does not apply)	
Pharmacy Name:	State License Number:
Address of Pharmacy:	Phone Number:
Supervising Pharmacist's Name (print):	Supervising Pharmacist's License Number(s):
Supervising Pharmacist's Signature:	Date (mm/dd/yyyy):

Washington State Department of Health
Pharmacy Quality Assurance
Commission Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of Current Active Pharmacy Practice

_____ has been employed as a
(Print applicant name clearly)

☐ Pharmacy Technician

☐ Pharmacist

☐ Other, please explain _____

by this organization from _____ until _____.
(mm/dd/yyyy) (mm/dd/yyyy)

Pharmacy/Employer Information:

Name _____ Phone (enter 10 digit #) _____

Pharmacy State License Number (if applicable)_____

Email Address_____

Street Address_____

City _____State _____Zip Code _____

Person Completing Form:

Name _____ Phone (enter 10 digit #) _____

Email Address_____

Credential type and number (if applicable) _____

Title _____

Signature _____ Date_____

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Washington State Department of Health
Pharmacy Technician Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Pharmacy Technician
Letter of Recommendation

Applicant's Name _____

To be completed by recommender:

I have known the applicant for approximately: _____ years _____months

My relationship to the applicant was (or is) in the following capacity:

☐ Employer ☐ Supervisor ☐ Co-worker

I hereby certify that I am a licensed pharmacist in good standing in the state of _____.

My license/certification number is: _____

I further certify that I have been personally acquainted with _____
and that to the best of my knowledge, I believe he or she is of good moral and professional character. I confirm that he or she is free from habits liable to interfere with his or her professional services.

Remarks:_____

_____

_____

_____

_____

Print Name: _____

Street Address or PO Box: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Daytime Phone (enter 10 digit #):_____

Signature: _____ Date: _____

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Washington State Department of Health
Pharmacy Quality Assurance
Commission Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Out-of-State Credential Verification

To Applicant:

Please complete this side of form and send it to the state(s) and/or jurisdiction(s) where you are or have been credentialed. Instruct them to return the form directly to the address listed below. Make a copy of this form if you are or have been credentialed in more than one state and/or jurisdiction. Credentialing agencies normally charge a fee to verify a credential, please check in advance to help expedite this process.

Name: Last	First	Middle
Mailing Address		
City	State	Zip Code
Any other names used		
Credential Number	Date Issued	

Have the licensing agency return this completed form to the above address.

Please call 360-236-4700 if you have questions regarding this form.

Out-of-State
Credential Verification Cont.

(To be Completed by the Regulatory Agency)

Please complete this form regarding the applicant listed on the reverse. Submit the completed form and any other requested material directly to this office at the address on the reverse. We will not accept the form if submitted by the applicant. Thank you.

Name of credential holder:		
Authority providing verification: (state, name & title)		
Applicant was credentialed by:		
☐ Written Examination	Date:	Score:
Name of examination:		
☐ Other Examination	Date:	Score:
Name of examination:		
Is credential current: ☐ Yes ☐ No	Expiration Date:	
Is this individual considered to be in good standing in your state? ☐ Yes ☐ No If "no", please attach explanation.		
Has this credential ever been denied? ☐ Yes ☐ No Suspended? ☐ Yes ☐ No Revoked? ☐ Yes ☐ No Surrendered? ☐ Yes ☐ No Reinstated? ☐ Yes ☐ No If "yes", please provide a copy of the final order or other documentation of action taken.		
If this credential holder has been disciplined, has he/she successfully completed all requirements and is currently in good standing? ☐ Yes ☐ No		

State Seal

_____
Signature:

_____
Title:

_____
Date:

Washington State Department of Health
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PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Law Study Verification

_____ 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 License number:

Pharmacist contact information:

Name:
Street:
City:
Phone (enter 10 digit #):
Date:
Email Address:

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RCW/WAC and Online Web Site 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 246-901

On-Line

AIDS Training Resources, Reference Page

Pharmacy Quality Assurance Commission, Web site