

2015 IOWA PHARMACIST LICENSE RENEWAL/REINSTATEMENT APPLICATION

REMINDER: Iowa law requires a pharmacist to notify the Board within 10 days of a change of legal name, residence address, or employment.

Please type or print clearly in ink. Make changes as necessary.

1 License No.: _____

Social Security No.: _____

LICENSE FEE: \$180.00 *

*Fee for License renewal between
July 1 & July 31, 2015: \$360.00

*Fee for License renewal between
August 1 & August 31, 2015: \$450.00

*Fee for License renewal between
September 1 & September 30, 2015: \$540.00

*Fee for License reinstatement after
September 30, 2015: \$630.00

2 Name, Address: _____

3 Iowa County _____

Home Telephone No.: (_____) _____

Remit check or money order payable to:

IOWA BOARD OF PHARMACY (**DO NOT SEND CASH**)

4 E-mail address: _____

5 Degrees in Pharmacy (check all that apply): ____ B.S. ____ Pharm.D. ____ Other (specify) _____

6 List all other states in which you are currently licensed to practice pharmacy: _____

DISCIPLINARY/CRIMINAL HISTORY:

7 Since initial licensure in Iowa or another state, has your license in any state been disciplined? *Discipline includes, but is not limited to, citations, reprimands, fines, license restrictions, probation, license surrender, suspension, or revocation.* If yes, provide a written explanation of the discipline on a separate sheet. Provide copies of documentation from the licensing authority regarding the discipline unless complete documentation has previously been provided to this Board.

____ yes ____ no When _____

8 Since your last license renewal application, have you been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime, other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of the conviction. For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon. Driving under the influence or driving while impaired is not a minor traffic offense and must be reported. If yes, provide a written explanation of the charge and the final outcome on a separate sheet. Provide copies of court documents related to each incident.

____ yes ____ no When _____

CONTINUING EDUCATION:

9 Are you a **resident of AND** are you currently **licensed to practice pharmacy in** another state that requires continuing education for pharmacist licensure? ____ yes ____ no If yes, State _____ License Expiration Date _____
(If yes, indicate the state and license expiration date. Out of state licensure and residence combine to satisfy Iowa's CE requirements UNLESS you are practicing pharmacy in Iowa. If you qualify under this provision, skip to Item 12.)

10 Is this your first license renewal following Iowa licensure by examination? ____ yes ____ no
If **yes**, you are **EXEMPT** from Iowa's continuing education requirement for **THIS RENEWAL ONLY** – skip to Item 12.
(You will be required to complete continuing education, as indicated in Item 11, on your next Iowa license renewal.)

11 **ACCREDITED/APPROVED CONTINUING EDUCATION ACTIVITIES ATTENDED OR COMPLETED.**

a) I hereby certify that I have completed the required 30 contact hours (3.0 CEUs) of continuing education (or alternate requirement provided by Board rules and described below) and that none of the credits relied on for this license renewal have previously been used for Iowa license renewal. I further certify that all credits relied on for this license renewal were obtained during the following 27-month license renewal period. _____ (initial)

RENEWAL PERIOD:

I hereby further certify, by initialing following each statement below, that I have completed the specific continuing education requirement or alternative indicated by the statement during the 27-month renewal period indicated above.
*(You may need to certify more than one statement regarding your CE activities. Initial following **each** statement that applies.)*

b) During the 27-month renewal period indicated, I have completed a minimum of 15 contact hours of CE in ACPE-provider activities dealing with drug therapy. The ACPE universal activity number for a drug therapy activity ends with "01" or "02." Only activities with identification numbers ending "01" or "02" will be accepted to fulfill this requirement. _____ (initial)

c) During the 27-month renewal period indicated, I have completed a minimum of 2 contact hours of CE in ACPE-provider activities in pharmacy law. The ACPE universal activity number for a pharmacy law activity ends with "03." _____ (initial)

d) During the 27-month renewal period indicated, I have completed a minimum of 2 contact hours of CE in activities dealing with medication or patient safety. ACPE-provider activities ending "05" may be used to fulfill this requirement. This requirement may also be fulfilled by completion of nonACPE-provider activities pursuant to 657 subrule 2.12(1)(a). _____ (initial)

e) If I am a pharmacist engaged in the administration of vaccines pursuant to rule 657—8.33, I have completed a minimum of 1 contact hour of CE dealing with vaccines. _____ (initial) or _____ (Not Applicable)

f) During the 27-month renewal period indicated, I was approved for exemption from CE requirements while continuing formal education in a health-related graduate program. _____ (initial) _____ (approved exemption period)

g) In lieu of traditional CE, I have completed and submitted with this application a continuing professional development (CPD) portfolio pursuant to rule 657—2.17. _____ (initial)

If you have not completed a total of at least 30 contact hours of CE (including a minimum of 15 hours in ACPE-provider activities dealing with drug therapy, 2 hours in ACPE-provider activities in pharmacy law, and 2 hours in activities dealing with patient or medication safety), OR have not met the CE requirements of another state in which you currently reside and are licensed to practice pharmacy, OR have not been granted an exemption from CE requirements, OR have not completed and submitted a continuing professional development portfolio pursuant to rule 657—2.17, you will be issued an INACTIVE license.

AN INACTIVE LICENSEE MAY NOT PRACTICE PHARMACY IN IOWA.

CURRENT PRACTICE/EMPLOYMENT:

12 Principal place of employment.

Business Name _____
Address _____
City _____ State _____ Zip _____

(a) Nature of pharmacy practice (if any) at this location (check one):

- | | | |
|--|--|--|
| <input type="checkbox"/> Community | <input type="checkbox"/> Mail Order/Managed Care | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Long-Term Care | <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Nuclear |
| <input type="checkbox"/> Correctional Facility | <input type="checkbox"/> Wholesale/Distribution | <input type="checkbox"/> Manufacture |
| <input type="checkbox"/> Education | <input type="checkbox"/> Government | <input type="checkbox"/> Other (specify) _____ |

(b) If primary employment is not in pharmacy or related practice, please indicate employment status (check one):

- Unemployed but Not Retired Retired Engaged in Other Practice (specify) _____

13 Are you currently practicing pharmacy in Iowa? yes no If yes, complete (a), (b), and (c) below.

(a) Iowa Pharmacy License Number of primary practice site: _____

(b) Nature of pharmacy employment in Iowa (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Proprietor/Sole Owner | <input type="checkbox"/> Partner | <input type="checkbox"/> Employee Manager (PIC, Director, Supervisor) |
| <input type="checkbox"/> Employee Pharmacist (Staff, Clinical) | <input type="checkbox"/> Retired Pharmacist, Occasional Relief Work (Approx. hrs/year) _____ | |

(c) Hours worked per week in pharmacy in Iowa. (Estimate the average number of hours spent each week in each of these practice settings. The sum of the hours should equal the total hours you typically work each week in pharmacy in Iowa.)

- | | | |
|---|---|--|
| <input type="checkbox"/> Independent Community Pharmacy | <input type="checkbox"/> Chain Pharmacy | <input type="checkbox"/> Long-Term Care Pharmacy |
| <input type="checkbox"/> Mail Order/Managed Care Pharmacy | <input type="checkbox"/> Hospital Pharmacy | <input type="checkbox"/> Home Health Care Pharmacy |
| <input type="checkbox"/> Industry (Wholesale, Manufacture, etc) | <input type="checkbox"/> Nuclear Pharmacy | |
| <input type="checkbox"/> Correctional Facility Pharmacy | <input type="checkbox"/> Other Phcy-related (Education, Government, Association, etc) | |

REMIT TO: IOWA BOARD OF PHARMACY
400 S.W. EIGHTH STREET, SUITE E
DES MOINES, IA 50309-4688
PHONE: (515) 281-5944

Information provided on this application may be disclosed pursuant to 657 IAC Chapter 14.

I hereby swear under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for revocation or other disciplinary sanctions against my license. I also understand that if my license is not renewed to active status prior to expiration, it is illegal to continue to practice pharmacy in Iowa.

SIGN HERE 

Signature of Licensed Pharmacist

Date

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO APPLICANT

Privacy Act Notice: Disclosure of your Social Security number on this license application is required by 42 U.S.C. §666(a)(13) and Iowa Code §§ 252J.8(1), 261.126(1), and 272D.8(1) (2009). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18 (2009).