IOWA PHARMACIST LICENSE REACTIVATION APPLICATION

A pharmacist whose Iowa pharmacist license has lapsed due to non-renewal and who wishes to reactivate their license should review 657 IAC 2.13(2) to determine the appropriate method for reactivation.

Eligibility Requirements

- An inactive pharmacist who has been actively practicing pharmacy during the last five years in any state or states which required continuing education during that five-year period shall submit proof of continued licensure in good standing in the state or states of such practice must submit the following:
  - Pharmacist License Reactivation Application
  - A check or money order for $675 made payable to the Iowa Board of Pharmacy (Do not send cash)
  - Proof that you have met the CE requirements of your active license(s)
  - Verification of an active license in good standing
- An inactive pharmacist who has been actively practicing pharmacy during the last five years in a state which does not require continuing education must complete one of the requirements outlined in 657 IAC 2.13(2)"b".
- An inactive pharmacist who has not been actively practicing during the past five years must complete one of the requirements outlined in 657 IAC 2.13(2)"c".
- An inactive pharmacist who has not been actively practicing for more than five years requires must petition the Board for reactivation.
- An inactive pharmacist is encouraged to contact Board staff to evaluate the requirements for reactivation.

Complete the attached Iowa Board of Pharmacy's pharmacist license reactivation application. This application is not to be used for nonresident pharmacy PIC registration reactivations. When completing this application, please be advised of the following:

- All sections of the application must be completed. **Incomplete applications will delay the reactivation of your license.** Unsigned applications will be returned.
- Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application or disciplinary action. If you are in doubt, answer "yes" and provide an explanation.

Criminal History Background Check

Once a completed application is received, a fingerprint packet will be sent to the mailing address indicated on the application. The fingerprint packet is to be completed by the applicant and returned to the Board for processing. **DO NOT SUBMIT A WAIVER OR FINGERPRINT CARD, BY ANY DELIVERY METHOD, BEFORE RECEIVING A BACKGROUND CHECK PACKET FROM THE BOARD. ANY WAIVER AND/OR FINGERPRINT CARD RECEIVED BEFORE THE BOARD'S PACKET IS SENT WILL BE DESTROYED.**

Disclosure of Medical Conditions, Criminal History, and Disciplinary Action:

Be advised that the application for pharmacist license renewal asks about any medical conditions you have that might impair your ability to perform the duties of a pharmacist. The Board also considers recent criminal history and disciplinary actions when renewing the license. As part of the application process, you will be asked questions about any recent criminal history and disciplinary actions.

If you have any questions concerning these requirements, please notify the Board office. We suggest you contact the Board office for information as to what documentation may be necessary for licensure. Contacting the Board office about any of these situations may avoid unnecessary delays at the time of application.

Fees:

Reactivation Application Fee – DO NOT SEND CASH	
Reactivation Fee (Applications postmarked after November 1 of the renewal year or for licenses that have been expired for greater than 120 days)	$630.00
Criminal Background Check Fee	$45.00

Reactivation fees are a non-refundable administrative fee

Applications postmarked after November 1 are subject to reactivation provisions identified in Iowa Code Section 147.11.

Submit the completed application with all attachments and a check or money order made payable to the Iowa Board of Pharmacy in the appropriate amount to:

Iowa Board of Pharmacy, 400 SW 8th St Ste E, Des Moines, IA 50309

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

Iowa Board of Pharmacy
400 S.W. 8th St. Ste. E
Des Moines, IA 50309-4688
515-281-5944https://pharmacy.iowa.gov/

☐ **Active Duty Military**
☐ **Veteran**

PHARMACIST LICENSE REACTIVATION APPLICATION

Please type or print legibly in ink. Complete all application sections and sign. **Incomplete or illegible forms will delay the reactivation of your license. Refer to the application instructions for fee due.**

License #:_____

LICENSEE INFORMATION							
Full Legal Name:	**(Last)**		**(First)**		**(Middle)**		
NABP e-profile ID:		**Previous/Other Name(s) Used:**					
PRIMARY ADDRESS:							
Street Address:							
Address:							
City:		**State:**		**Zip Code:**			
County:		**Email Address (*required*):**					
Telephone No. (*required*):	☐ Home ☐ Mobile If mobile, do you accept text messages ☐ Yes ☐ No						
MAILING ADDRESS (*if other than primary address*):							
Address:				**Suite #:**			
Address:							
City:		**State:**		**Zip Code:**			

PRIMARY EMPLOYMENT TYPE ***(select one)***			
Community Pharmacy ☐	**Mail Order/Managed Care** ☐	**Hospital** ☐	**Long-Term Care** ☐
Home Health Care ☐	**Nuclear** ☐	**Correctional Facility** ☐	**Drug Wholesale/Distribution** ☐
Drug Manufacturer ☐	**Pharmacy-related education** ☐	**Government** ☐	**Consultant** ☐
Other Pharmacy-related ☐	**Unemployed, not retired** ☐	**Retired from Pharmacy Practice** ☐	**Engaged in Other Practices** ☐

CURRENT PHARMACY PRACTICE LOCATION ***(Indicate your principal place of pharmacy employment)***					
Pharmacy Name:			**Pharmacy License No.:**		
Street Address:				**Suite #:**	
City:		**State:**		**Zip Code:**	
Are you the PIC: ☐ **Yes** ☐ **No**		**Date of hire if employment change since last renewal:**			

Nature and hours of pharmacy practice at this location *(Indicate the number of hours worked per week next to the practice type)*:		
Community ☐	Long-Term Care ☐	Mail Order ☐
Hospital-dispensing ☐	Hospital-clinical ☐	Home Healthcare ☐
Industry ☐	Nuclear ☐	Consulting ☐
Compounding-sterile ☐	Compounding-non sterile ☐	Correctional ☐
Telepharmacy-consulting ☐	Telepharmacy-dispensing ☐	

LICENSE INFORMATION *(List all states in which you are currently licensed to practice pharmacy)*

State:	License No.:	Date Issued:	Expiration Date:	Status:

BOARD CERTIFICATIONS (BPS)

Certification Type:	Certification #:	Status:	Original Date:	Effective Date:	Expiry Date:

CONTINUING EDUCATION *(review application instructions before completing this section. Additionally, an inactive pharmacist who has been actively practicing pharmacy during the last five years in any state requiring continuing education during that five-year period shall submit proof of licensure in good standing in the state of such practice.)*

Are you a resident of and are you currently licensed to practice pharmacy in another state that requires continuing education for pharmacist licensure? If yes, indicate the state and license expiration date. Out of state licensure and residence combine to satisfy Iowa's C.E. requirements UNLESS you are practicing pharmacy in Iowa. If you qualify under this provision, skip to Statewide Protocols

YES ☐ NO ☐ If yes, State _____ License No. _____ License Expiration Date _____

If no, please contact the Iowa Board of Pharmacy at 515-281-5088 for additional reactivation requirements. A license verification for the state indicated above is required to be submitted with this application.

STATEWIDE PROTOCOLS

Are you an authorized pharmacist who orders and administers vaccines?	**☐ YES**	**☐ NO**
If yes, have you completed at least one hour of ACPE-accredited continuing education with the ACPE topic designator "06" followed by the letter "P."	**☐ YES**	**☐ NO**
Are you an authorized pharmacist who orders and dispenses naloxone?	**☐ YES**	**☐ NO**

If yes, have you completed at least one hour of ACPE-accredited continuing education related to naloxone utilization (not required for each renewal)?	☐ **YES** ☐ **NO**
Are you an authorized pharmacist who orders and dispenses nicotine-replacement tobacco cessation products?	☐ **YES** ☐ **NO**
If yes, have you completed at least one hour of ACPE-accredited continuing education related to nicotine-replacement tobacco cessation product utilization (not required for each renewal)?	☐ **YES** ☐ **NO**

CRIMINAL HISTORY ***(If you answer yes, you must list all convictions below, attach additional pages if necessary. On a separate sheet of paper provide a signed and dated explanation and attach court records of the conviction(s))***	
Since your license expired, do you have any pending charges, or 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 disclose all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.)	
	☐ **YES** ☐ **NO**

DISCIPLINARY HISTORY (***includes, but is not limited to: citations, reprimands, fines, license or registration restrictions, probation, surrender, suspension, and revocation. If you answer yes to any of the questions below provide a description and attach final disciplinary orders)***	
Since your license expired have you been disciplined by any licensing authority?	☐ **YES** ☐ **NO**
Do you have any charges, or knowledge of any complaints or investigations, pending before any licensing authority?	☐ **YES** ☐ **NO**
Since your license expired have you been denied a license or registration by any licensing authority?	☐ **YES** ☐ **NO**

MEDICAL CONDITION (***If you answer yes to any of the questions below, on a separate sheet of paper provide a signed and dated explanation.)***	
Do you currently have a medical condition that in any way impairs or limits your ability to perform the duties of a pharmacist with reasonable skill and safety?	☐ **YES** ☐ **NO**
Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	☐ **YES** ☐ **NO**
Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to perform the duties of a pharmacist with reasonable skill and safety?	☐ **YES** ☐ **NO**
If YES to any of the above, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	☐ **YES** ☐ **NO**
If YES to any of the above, does your field of work, the setting, or the manner in which you perform the duties of a pharmacist, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	☐ **YES** ☐ **NO**

I hereby swear or affirm 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 denial, revocation, or other disciplinary sanctions against my pharmacist license. Information provided on this application may be disclosed pursuant to 657 IAC Chapter 14.

REQUIRED SIGNATURE:

Signature of Licensee: _____ Date: _____

Privacy Act Notice: Disclosure of your Social Security number on this application is required by 42 U.S.C. § 666(a)(13) and Iowa Code §§ 252J.8(l), 261.126(1), and 272D.8(1). The number will be used in connection with the collection of child support 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.

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