Montana Department of
LABOR & INDUSTRY

Montana Board of Pharmacy
PO Box 200513
301 S Park, 4th Floor
Helena, MT 59620-0512
Phone: 406-444-6880
Fax: 406-841-2305
Email: dlibsdpha@mt.gov Website: www.pharmacy.mt.gov

Licensing Requirements and Application Checklist
PHARMACIST INTERN

License Requirements for Pharmacist Intern

Below are the minimum requirements you must meet in order to be licensed in the state of Montana.

Licensing Requirements: MCA 37-7-105, MCA, 37-7-302, MCA 37-7-201(2)(c)(i), and ARM 24.174.602

1. Verification of all professional licenses you hold or ever have held. Verification must be sent directly to Montana from each state/province/territory.
2. Complete the Montana application as a:
    a. Student currently enrolled in an accredited pharmacy program.
    b. Graduate of an accredited pharmacy program serving an internship; or
    c. Graduate of a pharmacy program located outside the United States of America which is not accredited and who has completed the Foreign Pharmacy Graduate Examination Committee (FPGEC) Certification from the National Association of Boards of Pharmacy (NABP).
3. Be enrolled in an accredited pharmacy program and complete at least one day of the accredited pharmacy program.
4. Complete and comply with additional requirements after licensure as indicated in rule.
5. If immunization certified, submit proof of certification and CPR training for the license endorsement to be added at time the license is issued. (MCA 37-7-105)

PLEASE REVIEW THE MONTANA LAWS AND RULES AT www.pharmacy.mt.gov.

Checklist of Required Documents to Submit for Application for Pharmacist Intern

The following documents and additional forms are required in addition to the basic application. Some documents may be submitted directly by the applicant as part of the application. Others, such as transcripts, may need to be sent to the board directly from the source.

- ☐ Photo (can be driver's license), email, and permanent address (can be home rather than school address).
- ☐ Official license verification from states and jurisdictions in which the applicant holds or has ever held a professional license of any type (ARM 24.174.502(1)(c)).
- ☐ If applying as a foreign pharmacist graduate, submit proof of FPGEC Certification issued by NABP.
- ☐ If immunization certified, submit copy of certificate for an immunization certified endorsement to be added at time of licensure.
- ☐ Submit the Pre-Graduate Certificate of Education form from the school in which you are enrolled after at least one day of the accredited pharmacy program has been completed.
- ☐ If you answered yes to discipline questions:
    - Include a detailed explanation on the event(s) and documentation from the source (licensing board, federal agencies/programs, or civil/criminal court proceedings such as initiating/charging documents, final disposition/judgement documents, etc.).

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Application Fee(s) for Pharmacist Intern

The following fee(s) must be submitted with your application. Online applicants can pay using a credit card or e-check. If you submit a paper application you must submit a check payable to the Montana Board of Pharmacy. Do not mail cash.

- ☐ $50 Application Fee (one-time fee, no renewal required)

You can apply for a license online at https://ebiz.mt.gov/POL/ or download a paper application from the website. Online application is recommended.

Please include a valid e-mail address with your application. E-mail is the Department's primary form of communication.

If you have any questions about the application process or the licensing requirements please contact the Department of Labor and Industry Professional Licensing Bureau using the contact information at the top of this checklist.

AFFIX PHOTO HERE

PASSPORT SIZE

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Application for licensure as a Pharmacist Intern:

☐ In-State ☐ Out-of-State

Application Fee: $50

1. FULL NAME: _____
   Last First Middle
2. OTHER NAME(S) KNOWN BY _____
3. PERMANENT ADDRESS _____
   Street or PO Box # City and State Zip
4. PERMANENT EMAIL ADDRESS: _____

   Preferred Mailing Address: ☐ BUSINESS ☐ HOME E-MAIL_____
5. TELEPHONE ( ) _____ CELL ( ) _____
6. SOCIAL SECURITY NUMBER _____FOREIGN ID NUMBER _____
7. DATE OF BIRTH _____ ☐ FEMALE ☐ MALE
8. LICENSE NAME _____
   (State your name as it should appear on the registration if granted.)

Character, Endorsement, and Discipline Questions

9. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory.

State	License #	Issue Date	Expiration Date	License Type	Requested State Verification
					☐ Yes ☐ No
					☐ Yes ☐ No

PERSONAL HISTORY QUESTIONS
IMPORTANT INSTRUCTIONS AND NOTICE

1. Please read the following questions carefully. Giving an incomplete or false answer is unprofessional conduct and may result in denial of your application or revocation of your license. *See,* 37-1-105, MCA.
2. You have a continuing duty to update the information you provide in your application and supplemental responses, including while your application is pending and after you are granted a license.
3. Upon submittal of your application form, for every "yes" answer provided, you will receive a request for specific information or documents associated with the question. Your application is not complete until staff receive all information requested.

PERSONAL HISTORY QUESTIONS

1. Have you ever had any license, certificate, registration, or other privilege to serve as a volunteer or practice a profession denied, revoked, suspended, or restricted by a public or private local, state, federal, tribal, religious, or foreign authority? Yes ○ No ○

2. Have you ever surrendered a credential like those listed in number 1, in connection with or to avoid action by a public or private local, state, federal, tribal, religious, or foreign authority? Yes ○ No ○

3. Have you ever resigned to avoid discipline, been suspended, or been terminated from a volunteer or employment position? Yes ○ No ○

4. Have you ever been required to participate in a behavioral modification or assistance program in lieu of suspension or termination from a volunteer or employment position? Yes ○ No ○

5. Have you ever withdrawn an application for any professional license? Yes ○ No ○

6. As of the date of this application, are you aware of any pending complaint, investigation, or disciplinary action related to any professional license you hold? Yes ○ No ○

7. Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?) Yes ○ No ○

Note on Questions 8 and 9: Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 8 or 9 may qualify for participation in the Montana Professional Assistance Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

8. Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? Yes ○ No ○

9. Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? Yes ○ No ○

The following information is provided for Question 10 below:

A criminal conviction may not automatically bar you from receiving a license. For more information about how a criminal conviction may impact your application, consult the board or program website.

10. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or sentence deferred or suspended as an adult or “juvenile convicted as an adult” in any state, federal, tribal, or foreign jurisdiction? Yes ○ No ○

11. Are you now subject to criminal prosecution or pending criminal charges? Yes ○ No ○

12. Have you ever been disciplined, censured, expelled, denied membership or asked to resign from a professional society or organization? Yes ○ No ○

13. Have you ever had a civil judgment entered against you in a lawsuit for incompetence, negligence, or malpractice in practicing any profession? Yes ○ No ○

14. Have you ever been disqualified from working with children, elderly persons, mentally ill persons, or other vulnerable persons? Yes ○ No ○

15. Have you ever been placed on probation, restricted, reprimanded, suspended, revoked, resigned in lieu of action against you, or had other action taken against you by any hospital, clinic, health care facility, group medical practice, health maintenance organization, or third-party insurance provider, including Medicare and Medicaid? Yes ○ No ○

16. Are you currently on an exclusion list by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services prohibiting you from working in a facility receiving federal funding? Yes ○ No ○

17. Has your authority to prescribe, dispense, or administer drugs, including controlled substances, ever been denied, restricted, suspended, or revoked? Yes ○ No ○

18. Have you ever voluntarily surrendered or had your U.S. Drug Enforcement Administration registration placed on probation, restricted, suspended, or revoked? Yes ○ No ○

I authorize the release of information concerning education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Pharmacy. I hereby declare that the information included in this application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____

Signature of Applicant Date

PLEASE REVIEW THE MONTANA LAWS AND RULES AT www.pharmacy.mt.gov

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PRE-GRADUATE CERTIFICATE OF EDUCATION

- Please forward this form to your school of pharmacy to be completed by an official and submitted directly to the Board of Pharmacy via the above address or email.

I VERIFY THAT THE APPLICANT IS ENROLLED IN AN ACCREDITED SCHOOL OF PHARMACY AND HAS COMPLTED AT LEAST ONE DAY OF THE ACCREDITED PHARMACY PROGRAM.

INTERN APPLICANT'S NAME: _____
(Please Print)

Date at least one day of an accredited pharmacy program was completed: _____

Official's Signature: _____ Date _____

School of Pharmacy: _____

Address _____

City _____ State _____ Zip Code _____

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INTERNSHIP EXPERIENCE AFFIDAVIT

NOTE: This form must be completed by the intern and submitted to the Board of Pharmacy upon completion of each internship experience. If the internship exceeds 500 hours in length, the form should be submitted upon the completion of each 500 hours of experience.

Intern Name: _____ Phone/Cell _____

Current Address _____

Internship Site _____

Site Address _____

Approved Preceptor _____

Dates covered by report (from – to) _____

Intern Competency Assessment
To Be Completed by the Preceptor

Supervising Preceptor: Please rate the intern on the following items using the following scale:
1=Performs at a High Level 2=Performs Satisfactorily 3=Needs Improvement 4=Not Observed

1.	Intern's performance of technical functions	☐1 ☐ 2 ☐ 3 ☐ 4
2.	Intern's communication with patients	☐1 ☐ 2 ☐ 3 ☐ 4
3.	Intern's communication with health care professionals	☐1 ☐ 2 ☐ 3 ☐ 4
4.	Intern's communication with supervising preceptor	☐1 ☐ 2 ☐ 3 ☐ 4
5.	Intern's ability as a clinician	☐1 ☐ 2 ☐ 3 ☐ 4
6.	Intern's ability as a teacher	☐1 ☐ 2 ☐ 3 ☐ 4

Please comment on the intern's overall progress during this internship period:

Please comment on the areas in which the intern needs further training;

INTERN HOURS/NAME: _____

WEEKLY REPORT OF HOURS		
From (Date)	To (Date)	Number of Hours

Total Hours: _____

WEEKLY REPORT OF HOURS		
From (Date)	To (Date)	Number of Hours

Total Hours: _____

The Board office must receive this affidavit within 30 days after completion of an internship period. Credit for time spent in subsequent training periods will not be granted unless Notification of Internship Site, Evaluation of Internship Site, and Internship Experience Affidavits for preceding time are completed and received by the Board office.

The above information in the Weekly Report of Hours was taken from payroll or other records, which are available at the above address and may be examined upon reasonable notice by the Montana Board of Pharmacy or any of its inspectors.

Signature of Preceptor: _____

Subscribed and sworn to before me, this_____day of_____, 20____

_____
Notary Public

_____
State

_____
County

_____
Commission Expiration

If completing an IPPE requirement, please make a copy for the School of Pharmacy before you mail this to the Board

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NOTIFICATION OF INTERNSHIP SITE

INTERN INFORMATION:

Name: _____

Social Security#:_____

E-Mail Address _____

Current Mailing Address_____

City, State & Zip:
_____Phone/Cell:_____

PRECEPTOR INFORMATION:

Supervising Preceptor Name: _____License#:_____

Internship Site: _____

Email Address _____

Address:_____

City, State & Zip:_____

Date Internship Begins:_____

_____ _____
Intern Signature Date

_____ _____
Supervising Preceptor Signature Date

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EVALUATION OF INTERNSHIP SITE

NOTE: This form must be completed by the intern and submitted to the Board of Pharmacy upon completion of each internship experience. If the internship exceeds 500 hours in length, the form should be submitted upon the completion of each 500 hours of experience.

Intern Name_____ Phone No. _____

Current Address _____

E-Mail Address _____

Internship Site _____

Site Address _____

Supervising Preceptor_____

Dates covered by report (from – to) _____
Month/Day/Year

Please rate the amount of exposure to the following areas of pharmacy practice:
1 = Extensive 2 = Moderate 3 = Minimal 4 = None

1.	Drug distribution systems including dispensing activities	☐1 ☐ 2 ☐ 3 ☐ 4
2.	The use of drug products and dosage forms in practice settings	☐1 ☐ 2 ☐ 3 ☐ 4
3.	Sterile and/or non-sterile compounding	☐1 ☐ 2 ☐ 3 ☐ 4
4.	Daily operations and routines of the pharmacy	☐1 ☐ 2 ☐ 3 ☐ 4
5.	Management of inventory, purchasing, recalls	☐1 ☐ 2 ☐ 3 ☐ 4
6.	Accounting, budgeting and data management	☐1 ☐ 2 ☐ 3 ☐ 4
7.	Providing direct pharmaceutical care for patients	☐1 ☐ 2 ☐ 3 ☐ 4
8.	Counseling and monitoring for prescription and OTC products	☐1 ☐ 2 ☐ 3 ☐ 4
9.	Counseling and assessment for naturopathic, herbal, and other alternative products	☐1 ☐ 2 ☐ 3 ☐ 4

10.	Teaching about medical/surgical, supplies, devices and equipment	☐1 ☐ 2 ☐ 3 ☐ 4
11.	Interacting with other members of the health care team.	☐1 ☐ 2 ☐ 3 ☐ 4
12.	Responding to drug information requests	☐1 ☐ 2 ☐ 3 ☐ 4
13.	Applying laws and regulations to the practice of pharmacy	☐1 ☐ 2 ☐ 3 ☐ 4

Using the scale described below, please rate the following items:

1 = Excellent 2 = Satisfactory 3 = Needs improvement NA = Not applicable

1.	The preceptor's teaching ability was	☐1 ☐ 2 ☐ 3 ☐ **NA**
2.	The preceptor's responsiveness to the intern's learning needs was	☐1 ☐ 2 ☐ 3 ☐ NA
3.	The preceptor's supervision of the intern was	☐1 ☐ 2 ☐ 3 ☐ NA
4.	The preceptor's ability to communicate with the intern was	☐1 ☐ 2 ☐ 3 ☐ NA
5.	The orientation to the pharmacy operation on the first day was	☐1 ☐ 2 ☐ 3 ☐ NA
6.	The responsiveness of other pharmacists to the intern's learning needs was	☐1 ☐ 2 ☐ 3 ☐ NA
7.	The friendliness and helpfulness of other pharmacy employees was	☐1 ☐ 2 ☐ 3 ☐ NA
8.	The availability of references at the site was	☐1 ☐ 2 ☐ 3 ☐ NA
9.	The diversity of the learning experience at the site was	☐1 ☐ 2 ☐ 3 ☐ NA

Comments on your experience

Would you recommend this as an internship site for other students? ☐ Yes ☐ No

Please explain:

I have complied with all board regulations and the instructions for internship furnished to me at the time of my internship registration. I consider the above progress report of internship training to be a correct statement of fact.

Intern signature _____Date _____

The Board office must receive this notice within 30 days after completion of an internship period. Credit for time spent in subsequent training periods will not be granted unless Notification of Internship Site, Evaluation of Internship Site, and Internship Experience Affidavits for preceding time are completed and received by the Board office.

VERIFICATION OF LICENSURE

(This is not an endorsement certification)

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:
I am applying for a license to practice as an Intern in the State of Montana. The Board of Pharmacy requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF Pharmacy, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

_____ Name: _____
(Signature) (Please print)

Address: _____

_____

License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF _____

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

_____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

Signed: _____

BOARD SEAL

Title: _____

State Board: _____ Date: _____