

MONTANA BOARD OF PHARMACY
(301 S PARK, 4TH FLOOR, HELENA, MT 59601- Delivery)
P. O. Box 200513
Helena, Montana 59620-0513
(406) 841-2300 FAX (406) 841-2344
E-MAIL: dlibsdpba@mt.gov WEBSITE: pharmacy.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 30 days for processing from the date that the Board has a complete routine application)

A BUSINESS CANNOT OPERATE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE

LICENSE REQUIREMENTS FOR COMMUNITY PHARMACY: 24.174.801-822 ARM:

- ◆ Prior to conducting business, a pharmacy must secure a license and be registered with the Board
- ◆ Owner of the pharmacy is a registered pharmacist in good standing in the state of Montana
OR
- ◆ The manager or supervisor of the pharmacy is a registered pharmacist in good standing in the state of Montana and that the pharmacist will be actively and regularly engaged and employed in and responsible for the management, supervision and operation of such pharmacy
- ◆ The license registers the pharmacy to which it is issued and is not transferable. It is issued on the application of the registered pharmacist-in-charge, and which contains the sworn statement that the pharmacy will be operated in accordance with the provisions of the law
- ◆ To operate, maintain, open or establish more than one pharmacy, separate applications shall be made and separate licenses issued for each
- ◆ Upon closure of a certified pharmacy, the original license becomes void and must be surrendered to the Board within ten days
- ◆ Registered pharmacy technicians or technicians-in-training may be utilized pursuant to the written policies and procedures of the institution pharmacy. Exemptions to established ratios as defined in ARM 24.174.711 may be granted with Board approval.
- ◆ Each home infusion pharmacy must be licensed with **both** the Board of Pharmacy and with the Department of Health and Human Services (DPHHS). Information about licensing with DPHHS can be obtained at www.dphhs.mt.gov or by calling (406)444-1575
- ◆ Telepharmacy 24.174.1302 ARM:
 - A remote telepharmacy site shall be connected to its parent pharmacy via computer, video and audio link.
 - A site cannot be licensed as a remote telepharmacy site if it is located within a twenty mile radius of an existing pharmacy.
 - The registered pharmacy technician present at the remote telepharmacy site must be currently registered with the Board, current certification with the Pharmacy Technician Certification Board (PTCB) or Exam for Certification of Pharmacy Technician (ExCPT) and have at least 500 hundred hours experience as a pharmacy technician, technician-in-training, or experience deemed as equivalent by the Board.

FEES:
\$240 – (Non-Refundable) - Application Fee
\$75 – (Non-Refundable) - Dispense under the Montana Dangerous Drug Act
\$75 – (Non-Refundable) – Pharmacy Technician Utilization Plan

****Make check or money order payable to the Montana Board of Pharmacy****

DOCUMENTS: The following documents must be submitted to the Board office in order to complete the license application. Please make 8 ½" x 11" copies of the following and submit with your application.

- ◆ A schematic drawing (floor plan) and security of the pharmacy area

ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE

- ◆ Complete the Dangerous Drug Act application if this pharmacy will be dispensing controlled substances
- ◆ Complete the Technician Utilization Plan application if pharmacy technicians will be employed in this facility
- ◆ Complete the Pharmacist-in-Charge Agreement form
- ◆ Complete the Pharmacist-in-Charge Agreement (Non-Pharmacist Owner) form if applicable

APPLICATION PROCEDURES:

- ◆ When the application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- ◆ If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.
- ◆ Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

- ◆ Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.
- ◆ The applicant will be notified in writing of any deficient or missing items from the application file.
- ◆ Once a routine application is processed and approved a permanent license will be issued.

ADDITIONAL LAW AND RULE INFORMATION:

- ◆ According to ARM 24.174.814 Security of Pharmacy, each pharmacist, whole on duty shall be responsible for the security of the pharmacy, including provisions for effective control against theft or diversion of drugs
- ◆ A Schedule II controlled substance perpetual inventory shall be maintained and routinely reconciled in all pharmacies
- ◆ The pharmacy shall be secured at all times by either a physical barrier with suitable locks and/or an electronic barrier to detect entry by unauthorized persons at any time. Such barrier shall be approved by the Board or its designee before being put into use
- ◆ Prescription and other patient health care information shall be maintained in a manner that protects the integrity and confidentiality of such information as provided by the rules of the Board

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy staff at pharmacy.mt.gov or email at dlibsdp@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES ON THE WEBSITE

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Community

1. NAME _____

2. MAILING ADDRESS _____
Street or PO Box # City and State Zip

3. PHYSICAL ADDRESS _____
City and State Zip
EMAIL ADDRESS _____

4. TELEPHONE () _____ FAX () _____

5. Tax ID NUMBER _____

6. PHARMACIST-IN-CHARGE _____ MT LICENSE # _____

Address _____

City: _____ State: __ Zip Code _____

Phone _____ Fax _____

7. PLEASE LIST LICENSE NUMBER AND NAME OF BUSINESS IF PREVIOUSLY LICENSED IN MONTANA AND APPROXIMATE DATE OF CLOSURE FOR THIS LICENSE

REASON FOR CLOSURE:

Location Ownership Other _____

8. DESCRIBE THE SCOPE AND TYPE OF SERVICES TO BE PROVIDED BY THIS PHARMACY

9. Will Home Infusion Therapy be provided? Yes No
If, yes, proof of licensure the Montana Department of Health and Human Services (DPHHS) is required

10. Is this a telepharmacy? Yes No

11. PLEASE CHECK THE TYPE OF OWNERSHIP OR OPERATION AND ATTACH THE REQUIRED INFORMATION

Sole Proprietor Partnership Corporation Other _____

12. Has this business or the person in charge of this business who is listed on the application ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

13. Has this business or the person in charge of this business who is listed on the application ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

14. Has the person in charge of this business who is listed on this application ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

15. Has the person in charge of this business who is listed on this application ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

16. Has the person in charge of this business who is listed on this application ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

17. Has a licensing agency initiated or completed disciplinary action against this business or the person in charge of this business who is listed on this application? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source. Yes No

18. Has this business or the person in charge of this business who is listed on this application voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupational license in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

19. Has a complaint ever been made against this business or person in charge of this business who is listed on this application with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

20. Has this business or the person in charge of this business who is listed on this application ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

21. Has this business or the person in charge of this business who is listed on this application ever been censured, expelled, denied membership or asked to resign from a professional organization related to the profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source. Yes No

22. Has this business or the person in charge of this business who is listed on this application ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding the ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source. Yes No

23. Does this business or the person in charge of this business who is listed on this application have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a Detailed explanation and provide documentation from the source. Yes No

24. Have any civil legal proceedings been filed against this business or the person in charge of this business who is listed on this application by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition. Yes No

25. Does this business or the person in charge of this business who is listed on the application ever been convicted of a misdemeanor or felony crime or have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If answered yes, a detailed explanation must be submitted on the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years ago and that resulted in fines of less than \$200; and (2) convictions prior to your 18th birthday unless you were tried as an adult. Yes No

26. Has the person in charge of this business who is listed on this application ever been diagnosed with chemical dependency or another addiction, or participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source. Yes No

27. Has the person in charge of this business who is listed on this application ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation. Yes No

28. Has the person in charge of this business who is listed on this application ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation for the source. 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.

Signature of Applicant

Date

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PHARMACIST-IN-CHARGE FORM

LICENSE REQUIREMENTS 24.174.801(1) ARM PHARMACIES:

- ◆ Complete the Community Pharmacy application
- ◆ Submit the Pharmacist-in-Charge form and the Non-Pharmacist-Owner agreement if owner of pharmacy is different than Pharmacist-in-Charge

ADDITIONAL RULE:

- ◆ 24.174.805 Change of Pharmacist-in-Charge
When the pharmacist-in-charge of a pharmacy ceases to be the pharmacist-in-charge, the pharmacist will be held responsible for notifying the Board in writing of such termination of services
- ◆ Within 72 hours of termination of services of the pharmacist-in-charge, a new pharmacist-in-charge must be designated in writing on the appropriate Board approved form and filed with the Board

APPLICATION PROCEDURES:

- ◆ When the application file is complete, it will be processed and considered by Board staff for permanent registration. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- ◆ If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.
- ◆ Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

- ◆ Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.
- ◆ The applicant will be notified in writing of any deficient or missing items from the application file.
- ◆ Once a routine application is processed and approved a permanent registration will be issued.

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy staff at pharmacy.mt.gov or email at dlibsdpaha@mt.gov

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STATEMENT OF PHARMACIST-IN-CHARGE

For the purposes of satisfying the requirements of ARM 24.174.805, the following agreement has been entered into and submitted to the Montana Board of Pharmacy:

Name of Pharmacy _____ License # _____

Address of Pharmacy _____

City _____ State _____ Zip Code _____

Owner of Pharmacy _____

(Please complete "Non-Pharmacist-Owner agreement if owner of pharmacy is different than P.I.C.)

The signature below indicates that the Pharmacist-in-Charge of the above named Pharmacy and will be the Pharmacist-in-Charge until the present license expires; that if the undersigned ceases to be Pharmacist-in-Charge prior to the expiration of the license, the undersigned will notify the Board of Pharmacy of such fact and failure to do so may be cause for suspension or revocation of Pharmacists license; that the undersigned agrees fully and promptly to comply with the applicable federal laws, laws of the State of Montana, and the rules and regulations of the Board of Pharmacy governing this application, applicants business, and the sale of permitted drugs, pharmaceuticals, and commodities.

24.174.805 CHANGE OF PHARMACIST-IN-CHARGE (1) When the pharmacist-in-charge of a pharmacy leaves the employment of such pharmacy, the pharmacist will be held responsible for the proper notification to the board of such termination of services.

(2) Within 72 hours of termination of services of the pharmacist-in-charge, a new pharmacist-in-charge must be designated and an affidavit filed with the board. The license will then be updated to indicate the name of the new pharmacist-in-charge.

Signature _____

Please retain a copy of this form in the pharmacy and send the original to the Board office

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PHARMACIST-IN-CHARGE AGREEMENT
(NON-PHARMACIST OWNER)

For purposes of satisfying the intent of 24.174.805 ARM the following agreement has been entered into and submitted to Montana Board of Pharmacy, PO Box 200513, Helena, MT 59620-0513:

I, _____, duly designated agent for the
_____ (owner/corporation) do hereby vest exclusive authority
in _____, a licensed pharmacist in the State of Montana, and
Pharmacist-in-Charge for the _____ pharmacy, certified pharmacy
license number _____ to perform as follows:

That _____, R.Ph., license number _____, shall have exclusive authority to make and implement any decision which may directly or indirectly involve compliance with any of the provisions of Title 37, Chapter 7, Montana Code Annotated and Chapter 174 of the Administrative Rules of Montana. That the parties hereto expressly agree and understand that in no event shall any person or persons, by virtue of his or their position in the corporation or for any other reason, substitute his or their judgment for that of the pharmacist-in-charge on matters involving the aforementioned compliance; that the parties further agree and understand that the continued right of the corporation to own and operate this pharmacy is contingent upon the existence and implementation of this agreement; and that the corporation agrees and understands that at such time as a new pharmacist-in-charge is designated, that a new agreement must be executed with that person and submitted to the Montana Board of Pharmacy.

Signed and dated this _____ day of _____, 20____.

Agent for the Corporation

Pharmacist-in-Charge

Please retain a copy of this form and send the original to the Board office

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LICENSE REQUIREMENTS FOR MONTANA DANGEROUS DRUG ACT
50-32-301 MCA

24.174.1401 Dangerous Drug Act

- ◆ Complete a Certified Pharmacy application Community or Montana License Number if already licensed as a Certified Pharmacy and adding dispensing to license
- ◆ Complete the Dangerous Drug Act application if this pharmacy will be dispensing controlled substances

FEE: \$75 – (Non-Refundable) - Dispense under the Montana Dangerous Drug Act

APPLICATION PROCEDURES

- ◆ When the application file is complete, it will be processed. The applicant may be notified if additional information is required.
- ◆ Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES

- ◆ Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.
- ◆ The applicant will be notified in writing of any deficient or missing items from the application file.
- ◆ Once a routine application is processed and approved a permanent license will be issued.

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy staff at pharmacy.mt.gov or email us at dlibsdpba@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES ON OUR WEBSITE

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APPLICATION FOR REGISTRATION UNDER THE MONTANA DANGEROUS DRUG ACT

Dispense

Business Name: _____

Authorized Individual: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

DEA Registration Number: _____ Federal Tax I.D. Number: _____

Montana License Number if already licensed and adding dispensing to license _____

Signature _____ Date _____
(Signature of applicant or authorized individual)

Title _____

NOTE:

The application for DEA Number may be obtained at www.dea.gov
DEA will be notified when a Montana Pharmacy license has been issued

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PHARMACY TECHNICIAN UTILIZATION PLAN

LICENSE REQUIREMENTS 24.174.712 ARM; and 37-7-307, 37-7-308 and 37-7-309, MCA

- ◆ Complete Community Pharmacy application
- ◆ An application on a form prescribed by the Board and the appropriate fee
- ◆ Summary of the utilization plan, to include information showing compliance with all requirements set forth in these rules, plus all other requirements of 37-7-307, 37-7-308, and 37-7-309 MCA
- ◆ Name and qualifications of the supervising pharmacist(s)
- ◆ Any number of registered pharmacists employed in the same pharmacy may sign as supervising pharmacist of a pharmacy technician on a single utilization plan submitted for approval to the Board by that pharmacy
- ◆ Summary of the tasks delegated by the pharmacist and the methods by which a supervising pharmacist may verify and document the tasks. "Verify" means the personal confirmation by a supervising pharmacist of the correctness of the tasks undertaken by the pharmacy technician.
- ◆ A registered pharmacist in good standing may supervise the services of no more than three technicians at any time. The 1:3 pharmacist to pharmacy technician ratio may be revised by the Board at any time for good cause.

FEES \$75 (Non-Refundable)–Application Fee

****Make check or money order payable to the Montana Board of Pharmacy****

DOCUMENTS

The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application:

- ◆ Copy of the Technician Utilization Plan

APPLICATION PROCEDURES

- ◆ When the application file is complete, it will be processed and considered by Board staff for approval. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- ◆ If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.
- ◆ Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES

- ◆ Once a routine application is complete, the application takes up to 5 days to process from the time it is received in the Board office.
- ◆ The applicant will be notified in writing of any deficient or missing items from the application file.

ADDITIONAL STATUTE AND RULE INFORMATION

- ◆ The supervising pharmacist shall make the utilization plan available for inspection by the Board during the normal business hours of the pharmacy
- ◆ The pharmacy technician shall make their training record available for inspection by the Board during the normal business hours of the pharmacy
- ◆ Any changes in the utilization plan, including technician training, must be resubmitted to the Board for approval before implementation of the changes by the supervising pharmacist

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy staff email at dlibsdpaha@mt.gov or visit the website at: pharmacy.mt.gov

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Pharmacy Technician Utilization Plan

PHARMACY NAME _____ LICENSE # _____

MAILING ADDRESS: _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE NUMBER: _____

FAX NUMBER: _____

ATTACH A COPY OF THE PHARMACY'S TECHNICIAN UTILIZATION PLAN

SUPERVISING PHARMACIST(S)

Name: _____ MT License # _____

Name: _____ MT License # _____

Name: _____ MT License # _____

Name: _____ MT License # _____

Name: _____ MT License # _____

PHARMACY TECHNICIAN(S) EMPLOYED IN THE PHARMACY

Name: _____ MT License # _____

Name: _____ MT License # _____

Name: _____ MT License # _____

Name: _____ MT License # _____

Name: _____ MT License # _____

I (we) do solemnly swear and affirm that I (we) have read and understood the Montana Pharmacy Technician Utilization Plan statutes and rules and that all statements made in this application for approval are true and correct in all respects.

SIGNATURE(S) OF SUPERVISING PHARMACIST(S)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

You must submit any amendments to this plan to the Montana Board of Pharmacy office in writing within 10 days of the changes.

I authorize the release of information concerning my 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 under penalty of perjury the information included in my 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 _____ Date _____