AFFIX PHOTO HERE

PASSPORT SIZE

Montana Board of Pharmacy

PO Box 200513
301 S Park, 4th Floor
Helena, MT 59620-0512
Phone: 406-841-2300
Fax: 406-841-2305
Email: dlibsdpha@mt.gov Website: www.pharmacy.mt.gov

Application for licensure as a Pharmacist Intern:

☐ In-State ☐ Out-of-State

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**

10. Are you requesting the immunization certification endorsement on your license? If yes, attach proof of immunization certification and CPR training. ☐ Yes ☐ No
11. Have you ever had an application for a professional or occupation license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No
12. Have you ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application?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
13. Have you 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

14. Have you ever withdrawn or been suspended, placed on probation, expelled or Requested to resign from any postsecondary educational program?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

15. Have you 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

16. Has a licensing agency initiated or completed disciplinary action against Any professional or occupational license you have held? 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

17. Have you ever 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

18. Has a complaint ever been made against you with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source. ☐ Yes ☐ No

19. Have you 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

20. Have you 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

21. Have you ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding your 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

22. Do you 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

23. Have any civil legal proceedings been filed against you 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

24. Have you ever been convicted of a misdemeanor or felony crime or do you 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 you answer yes, a detailed you must submit a detailed explanation 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

25. Have you ever been diagnosed with chemical dependency or another addiction, or have you 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

26. Have you 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

27. Have you ever been court-martialed 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 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 of Applicant Date

Allow 30 days for licensure from the date the Board has a complete routine application.

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: _____