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

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

**INTERNS ARE NOT PERMITTED TO PRACTICE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA REGISTRATION**

**INTERNSHIP REQUIREMENTS 24.174.602 INTERNSHIP REQUIREMENTS:**
An intern shall be:

- A student currently enrolled in an accredited pharmacy program;
- A graduate of an accredited pharmacy program serving an internship; or
- A graduate of a pharmacy program located outside the United States of America which is not accredited and who has successfully passed equivalence examinations approved by the Board.

Applications Requirements:

- Application shall be made on the intern application form prescribed by the Board and required fee. Registration must be obtained prior to commencing work as an intern.
- An intern registration may be issued to a student currently enrolled in an accredited pharmacy program at any time after they have completed 30 days of study,
- Intern registration based on enrollment in or graduation from an accredited pharmacy program shall expire not later than 12 months after the date of graduation or at the time of professional licensure, whichever comes first. Intern registration based on graduation from a pharmacy program located outside of the United States of America which is not accredited shall expire not later than 12 months after the date of issuance of the registration or at the time of professional licensure, whichever comes first.
- An intern registration may be extended subject to approval by the Board, upon application by the intern, if extenuating circumstances are present.
- No renewal is required.

**ADDITIONAL REQUIREMENTS:**

- Pre-Graduate Certificate of Education

**FEE: $80.00 (Non-Refundable) Application Fee**
**Make check or money order payable to the Montana Board of Pharmacy**

**PHOTO:** Attach photo to page 3 of the application. Passport size is preferable.

**ADDITIONAL RULE INFORMATION:**

- The experience required for licensure shall be that instruction period composed of computed time obtained under the supervision of the preceptor in an approved site.
- An intern may practice only under the immediate personal supervision of a supervising pharmacist.
- The intern shall make such reports and certifications as required under the approved program.
- The intern shall make such reports and certifications as required under the approved program and as required by the Board.
- The intern is responsible for the knowledge and observation of the extent of the intern's legal liability and legal restrictions applicable under the federal state, and municipal laws and rules
- The intern shall be responsible for ensuring that the preceptor has proper certification
- The intern is responsible for properly submitting all forms and hour reports under the approved program

- Employment and the intern training periods are not be interpreted as being the same. An intern may work in excess of the computed time.
- The intern shall notify the Board of any change of address, employment or preceptor within ten days.
- Intern certificate of registration shall be displayed in the approved training area.

**OUT-OF-STATE INTERNSHIP REQUIREMENTS:**

- Written request by the intern must be made to the Board prior to commencing training at an out-of-state site
- The intern must comply with the rules relating to internship and the approved program
- The intern must obtain certification of the training area and the preceptor from the out-of-state's Board and must submit the same directly to the Montana Board of Pharmacy.

**APPLICATION PROCEDURES:**

- When the application file is complete, it will be processed and considered by Board staff for registration. The applicant will 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.
- All verifications of licensure must be sent directly from each state board in which the applicant is currently or has ever been licensed. Please make copies of the attached verification request form as needed. Some states may charge a fee for verifications. Contact each state board prior to sending the request.
- 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 registration will be issued.

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

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AFFIX PHOTO HERE

PASSPORT SIZE

**Intern**

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.)

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. 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

11. 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

12. 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

13. 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

14. 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

15. 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

16. 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

17. 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

18. 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

19. 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

20. 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

21. 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

22. 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

23. 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

24. 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

25. 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

26. Have you 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 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

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# PRE-GRADUATE CERTIFICATE OF EDUCATION

**Please forward this form to your school of pharmacy to be completed by an official of a Board approved School of Pharmacy and sent directly to:**

**MONTANA BOARD OF PHARMACY**
**PO BOX 200513**
**HELENA MT 59620-0513**

**I VERIFY THAT THE NAMED APPLICANT IS CURRENTLY ENROLLED AND IN GOOD ACADEMIC STANDING IN AN ACCREDITED PHARMACY PROGRAM AND HAS COMPLETED MORE THAN 30 DAYS OF STUDY.**

**Name (please print):** _____

**Date that 30 days of study 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 _____ Phone No. _____

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;

NAME OF INTERN: _____

| 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:_____

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**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_____ 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.

STATE BOARD:

_____ 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 _____

**BOARD SEAL**

Signed: _____
Title: _____
State Board: _____ Date: _____