PSP

IOWA BOARD OF PHARMACY
INITIAL PHARMACY SUPPORT PERSON REGISTRATION APPLICATION

Registration No. & Expiration: _____
(assigned by Pharmacy Board)

REGISTRATION FEE: $25.00
Failure to register within 30 days of starting employment as a pharmacy support person requires payment of an additional fee of $25 **(total fee $50).**

PLEASE TYPE OR PRINT CLEARLY IN INK.

1. Name, Residence/Mailing Address:

_____

_____

_____

Remit check or money order payable to:
IOWA BOARD OF PHARMACY
(DO NOT SEND CASH)

A registration to practice as a pharmacy support person is subject to periodic renewal. Check your registration certificate for the expiration date.
It is your responsibility to timely renew the registration and to report any change of name, address, or employment status within 10 days of a change.

2. Iowa County of Residence: _____
3. Home Telephone No.: (____)_____
4. Gender: ☐ Male ☐ Female
5. Social Security No.: _____
6. Date of Birth: _____

E-Mail Address: *(optional)* _____

7. Do you currently have any physical or mental condition that in any way impairs or limits your ability to perform the duties of a pharmacy support person with reasonable skill and safety or have you ever used any drugs, alcohol, or other chemical substances that in any way impair or limit your ability to perform the duties of a pharmacy support person with reasonable skill and safety?
☐ NO ☐ YES If you responded 'yes,' please explain on a separate sheet.

8. Have you ever been charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime (*other than minor traffic violations with fines under $100*)?
☐ NO ☐ YES If you responded 'yes,' please explain on a separate sheet.

9. Have you ever had a health profession license or registration *(pharmacy technician, pharmacist, nurse, physician, etc.)* issued in Iowa or another state suspended, revoked, or disciplined?
☐ NO ☐ YES If you responded 'yes,' please explain on a separate sheet.

10. CURRENT EMPLOYMENT:
Indicate **all** Iowa pharmacies where you are **currently** employed as a pharmacy support person or are (or will be) performing functions requiring pharmacy support person registration. Please include the Iowa license number for each pharmacy and the month and year employment as a pharmacy support person began (or is scheduled to begin).

PHARMACY NAME, ADDRESS, CITY	PHARMACY LIC.#	DATE HIRED	HOURS/WEEK

11. EDUCATIONAL BACKGROUND:

Circle highest grade completed

1 2 3 4 5 6 7 8 9 10 11 12 High School Graduate or Equivalent (GED)? ☐ Yes ☐ No

Name and location of schools or training **BEYOND high school**	Dates Attended MM/YY	MM/YY	Field of Study	Degree Obtained

12. EMPLOYMENT EXPERIENCE:

List your employment experience for the past two years, starting with the most recent. Do not include current employment which you have already listed in Item 10 on the reverse.

BUSINESS/COMPANY NAME	POSITION TITLE	COMPANY ADDRESS	CITY, STATE, ZIP	DATES EMPLOYED

REMIT TO: IOWA BOARD OF PHARMACY
400 S.W. EIGHTH STREET, SUITE E
DES MOINES, IA 50309-4688
PHONE: (515) 281-5944

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

PRIVACY ACT NOTICE: Disclosure of your Social Security number on this registration application is required by 42 U.S.C. §666(a)(13) and Iowa Code §§252J.8(1) and 261.126(1) (2007), and Iowa Code §272D.8(1) (Supp. 2008). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify registrants, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18 (2007).

I hereby swear 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 pharmacy support person registration.

SIGN HERE ⇨ _____ _____

Signature of Pharmacy Support Person Applicant *Date*

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO THE APPLICANT

You must notify the Board of any change of name, address, telephone number, and employment. You must notify the Board if you discontinue working as a pharmacy support person or if you begin working as a pharmacy technician.