Arkansas State Board of Pharmacy

322 South Main Street, Suite 600 Little Rock, AR 72201
P: 501.682.0190 F: 501.682.0195
asbp@arkansas.gov • www.pharmacyboard.arkansas.gov
John Clay Kirtley, Pharm.D., Executive Director

Reinstatement of a Pharmacist License

Carefully follow the directions on this application form. In addition, note the following:

1. The registration and application fees are NOT refundable.
2. Your application is NOT considered complete until all supporting documents and fees have been received by the Arkansas State Board of Pharmacy.
3. If the name shown on your supporting documentation is different from that shown on your application, you must submit proof of legal name change – a certified copy of your marriage license, divorce decree, affidavit or court order.
4. Practice after inactivity when reciprocating or reinstating a license is specified in Regulation 02-00-0003 found below.

Supporting Documentation and Fees:

Submit the following documents and fees:

1. A copy of your driver's license with this application.
2. A copy of your birth certificate.
3. A check or money order for made payable to the *Arkansas State Board of Pharmacy* for your application for reinstatement as determined on Page 3 of the application.
4. A criminal background check.
   - You must complete and send a Criminal Background Check Identity Verification Form.
   - A check made payable to the Arkansas State Board of Pharmacy in the amount of $36.25 for the state and federal criminal background check fees.
   - A completed fingerprint card. **You MUST use a standard FBI fingerprint card, form No. FD-258 used by the FBI for noncriminal fingerprinting**. You can contact the State Board of Pharmacy office to have one sent to you. Email your mailing address to asbp@arkansas.gov or call (501) 682-0190 to request a card. If you are an in-state applicant, please contact the Board for an alternate fingerprinting process.
5. All proof of hours of continuing education required to reinstate.
6. Supplemental information as specified in the application.
   - An applicant who has a criminal conviction may seek to have the conviction waived and the application approved, subject to appropriate terms and conditions. The request for waiver shall be on a form provided by the Board and shall be accompanied by all documentation specified in Parts IV, V and VI that have not already been delivered to the Board. The request for waiver shall not be considered until the application, all fees, all the documentation, both federal and state criminal background check reports, and a request for wavier form stating the applicant's reasons why the conviction should be waived are received by the Executive Director.

02-00-0003—PRACTICE AFTER INACTIVITY WHEN RECIPROCATING OR REINSTATING A LICENSE

(a) To be reinstated and immediately practice without supervision, the pharmacist's license shall not have lapsed more than two calendar years.

(b) To be reciprocated and immediately practice without supervision, the pharmacist shall have practiced the profession of pharmacy, as defined by law, in a licensed facility at least forty (40) hours per year in the previous two calendar years.

(c) If these criteria are not met, the pharmacist must:
   a. Prior to resuming the unsupervised practice of pharmacy, practice 40 hours under direct pharmacist supervision of an Arkansas licensed pharmacist for each year or part of year out of practice. This time under supervision shall not exceed 240 hours.
   b. Cause the supervising pharmacist to document in writing to the Board, that the pharmacist has completed the designated number of hours of supervised practice.
   c. Meet with a Board representative in a practice situation so that the Board representative can, by observation, questioning, and other methods, ensure that the pharmacist is able to competently practice pharmacy. (10/12/93)

Arkansas State Board of Pharmacy

322 South Main Street, Suite 600
Little Rock, AR 72201
P: 501-682-0190 • F: 501-682-0195
www.pharmacyboard.arkansas.gov

TAPE A COLOR PHOTOGRAPH TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION IN THIS SPACE

APPLICATION FOR REINSTATEMENT OF AN ARKANSAS PHARMACIST LICENSE

The Arkansas State Board of Pharmacy is **required** under 42 USC § 666(a)(13) and Ark. Code Ann § 17-1-104 to obtain the social security numbers of all licensees to provide to the Arkansas Office of Child Support to assist in the identification of persons who are delinquent in complying with a child support order, spousal support/alimony order or in the repayment of educational loans. Your social security number will also be used for the required criminal background investigation.

PART I: APPLICANT INFORMATION

ARKANSAS PHARMACIST LICENSE #: **PD** **ORIGINAL LICENSE DATE:**

SOCIAL SECURITY NUMBER: **GENDER:** (check one) ☐ Male ☐ Female

RACE: ☐ White ☐ Black/African American ☐ Asian ☐ American Indian / Alaska Native ☐ Other: _______________

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

NAME: Last First Middle Suffix (Jr.)

OTHER NAMES USED: Identify any maiden name, surname, or any other names or aliases you have been known by or used and identify the reason for your name change.

DATE OF BIRTH: **PLACE OF BIRTH** (list city, county, state or other jurisdiction, country):

PHYSICAL ADDRESS: (Street, City, State, Zip)

MAILING ADDRESS: if different from address listed above.

HOME PHONE NUMBER: ( ) **WORK PHONE NUMBER:** ( )

CELL PHONE NUMBER: ( ) **FAX PHONE NUMBER:** ( )

EMAIL:

CITIZENSHIP:

a. Are you a Citizen of the United States? YES ☐ NO ☐

b. If you answered NO to question 19 (a) above, are you: (Please check one of the following.)

- ☐ a qualified alien (as defined in 8 U.S.C. § 1641.)
- ☐ a nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 et seq.)
- ☐ an alien who is paroled into the United States under 8 U.S.C. § 1182 (d)(5) for less than one year.
- ☐ other – please provide a detailed explanation.

PART II: EMPLOYMENT INFORMATION

Will you practice pharmacy while physically present in the State of Arkansas? YES ☐ NO ☐

EMPLOYER:

EMPLOYER ADDRESS:
(Street, City, State, Zip)

PHONE: **FAX:**

WEBSITE:

Is your employer currently licensed by the Arkansas State Board of Pharmacy? YES ☐ AR License #: NO ☐

Have you practiced pharmacy, as defined by law, in a licensed facility at least 40 hours per YEAR in the previous two calendar years? YES ☐ NO ☐

FOR OFFICE USE ONLY:

License #: PD Date Issued: Fee Paid: Check No.:

PART III: QUALIFICATIONS AND IDENTIFICATION

School of Pharmacy Graduated: ______________________________

Pharmacy Degree(s) Earned: ______________________________

Date of Graduation: ______________________________

PART IV: RECORD OF LICENSURE INFORMATION

If you have ever been licensed, certified or registered to practice pharmacy (as a technician, intern or pharmacist), or held any other professional license, certification or registration, complete the information below – if you need additional space, use a separate sheet of paper to complete this section.)

Jurisdiction	Title of License, Certification or Registration	License, Certificate or Registration Number	Date of Issue	In Good Standing? **Answer yes or no*.**

*(If any licenses are not current and in good standing, please explain why on a separate sheet.)

PART V: PERSONAL HISTORY INFORMATION

You must respond fully and truthfully to these questions and, if the answer is "Yes" to any part of these questions, you **must** provide a notarized written detailed explanation of the circumstances.

You must fully and truthfully report your criminal history whether or not the arrest/citation was dismissed, dismissed through drug court diversion, expunged under the first offender act, alternative sentencing act, Act 531, Act 305,or Act 346 or it happened over 5 years ago. This criminal history includes all DWI, DUI, and MIP (Minor in Possession) violations, possession of controlled substances, theft, shoplifting, domestic violence, assault violations, or any other violation of any state or federal law, whether misdemeanor or felony, and regardless of the state or territory in which it happened.

If you do not fully and truthfully report your history, your application will be denied and/or you will be subject to other sanctions. Please contact the Arkansas State Board of Pharmacy at 501-682-0190 if you do not understand the above information.

Have you had any application for any professional license or registration refused or denied by any licensing authority?	YES ☐	NO ☐
Have you ever voluntarily surrendered a professional license or registration?	YES ☐	NO ☐
Have you ever been the subject of a disciplinary action with regard to any license or registration?	YES ☐	NO ☐
Have you ever had a license or registration revoked, suspended or subjected to other disciplinary action?	YES ☐	NO ☐
To your knowledge, have any unresolved or pending complaints ever been filed against you with any professional licensing agency or association?	YES ☐	NO ☐
Is there any disciplinary action pending against you by any licensing jurisdiction, the USDA, Drug Enforcement Agency, or any state drug enforcement authority?	YES ☐	NO ☐
Have you ever been cited, arrested for, charged with, or convicted of (including a *nolo contendere* plea or guilty plea) a criminal offense in any state or in federal court (other than minor traffic violations) whether or not sentence was imposed or suspended?	YES ☐	NO ☐
Have you ever been pardoned from a criminal conviction?	YES ☐	NO ☐
Have you ever had a record expunged?	YES ☐	NO ☐
Have you ever been cited, arrested for, charged with, or convicted of (including a nolo contendere plea or guilty plea) a violation of any federal or state drug law(s) or rule(s) whether or not sentence was imposed or suspended?	YES ☐	NO ☐
Are you now or have you in the last 5 years been treated for a drug or alcohol addiction or participated in a rehabilitation program?	YES ☐	NO ☐
Do you currently have an alcohol or other substance abuse problem?	YES ☐	NO ☐
Within the last five (5) years have you had a license or certification revoked or suspended, other disciplinary action taken, or an application for licensure or certification refused, revoked or suspended by any professional licensing authority of another state, territory or country?	YES ☐	NO ☐

PART VI: PROOF OF IDENTIFICATION AND CONTINUING EDUCATION

With your application, please submit copies of:

- Your birth certificate
- Your valid driver's license, *OR* a valid state ID card with photo, *OR* a valid passport

To reestablish active status and return to practice in Arkansas, a pharmacist must acquire half of the continuing education hours missed plus the continuing education hours for the current licensure period up to 60 hours. If the pharmacist has been on inactive status with regard to continuing education for two (2) calendar years or more and has not been actively practicing pharmacy in another state, said pharmacist shall also comply with all requirements in regulation 02-00-0003.

PART VII: CERTIFICATIONS

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of Arkansas to the truth and accuracy of all statements and representations made in this application and that I personally completed the application. I understand that I must notify the Board in writing of any change of address or employment. I have read and understand the instructions and statements on this application.

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge, and that the copy of my driver's license or other identifying photographic identification attached hereto is a true likeness of myself. I authorize the Arkansas State Board of Pharmacy to review state files pertaining to my registration and practice, and all law enforcement records, administrative records, motor vehicle records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization of entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

____

Signature of Applicant (Full Legal Name)   Date Signed

Check your application to make sure it is complete and you have included all required documentation. Incomplete applications will delay the processing of the application. The application will expire 1 year from date of receipt. Application fees will not be refunded. Send the completed application AND APPROPRIATE FEES (see below) to:

Arkansas State Board of Pharmacy, 322 South Main Street, Suite 600, Little Rock, AR 72201

Please make your check or money order payable to the: Arkansas State Board of Pharmacy

REINSTATEMENT FEE: The reinstatement fee is $75.00 for each year or part of a year that the license has lapsed up to a maximum of $300.00 Number of years /part years lapsed _____ X $75.00 = ___________. Enter this amount in the column to the right or $300.00, whichever is **less.**	
LICENSE FEE: If the date of your application falls in an even numbered year (i.e. 2024, 2026, 2028) the fee is $150.00 and your license will expire on December 31 of the next odd numbered year. If the date of your application falls in an odd numbered year (i.e. 2025, 2027, 2029) the fee is $75.00 and your license will expire on December 31 of the current year. Even numbered year = $150.00; Odd numbered year = $75.00 Enter the appropriate amount in the column to the right.	
CRIMINAL BACKGROUND CHECK FEE: Please complete and submit a Criminal Background Check Identity Verification Form and fingerprint card with this application and include the background check fees of $36.25.	
TOTAL APPLICATION FEE: The FEE for this application for reinstatement is the **Reinstatement Fee** plus **License Fee** plus **Criminal Background Check Fee**. Add all applicable fees and enter the total due in the column to the right. **(PAY THIS AMOUNT ONLY)** Total Due:	

Criminal Background Check Identity Verification Form Instructions

Criminal Background Check Identity Verification Form:

- Fill out all the required boxes on the fingerprint card using the information below prior to taking the fingerprints.
- Fill out all the required information on the Criminal Background Check Identity Verification Form prior to taking the fingerprints.
- Once fingerprinted, have the person that took your prints fill out the "Fingerprint Technician Information" portion of the Criminal Background Check Identity Verification Form and seal the fingerprint card and the Criminal Background Check Identity Verification Form in a signed envelope. You'll submit this sealed and signed envelope with your completed application to the Board of Pharmacy.

FBI Fingerprint Card:

- **You MUST use a standard FBI fingerprint card, form No. FD-258 used by the FBI for noncriminal fingerprinting.** You can contact the State Board of Pharmacy office to have one sent to you. Email your mailing address to asbp@arkansas.gov or call (501) 682-0190 to request a card.
- Have fingerprints done by someone **APPROPRIATELY TRAINED** to collect them. **A delay in the processing of your FBI criminal background check is commonly caused by incomplete FBI fingerprint cards and poor quality of fingerprints.**
  - Your local police or sheriff's department may be willing to accommodate you. There may or may not be a fee involved. The Arkansas State Police ID Bureau in Little Rock, on Geyer Springs Road at I-30, will do your fingerprints **WITHOUT** charge Monday through Friday from 8:30 a.m. to 4:30 p.m.
- **DO NOT BEND OR FOLD THE FBI FINGERPRINT CARD**.
- **DO NOT CONTACT the Arkansas State Police or the FBI** about the status of your criminal background check. Those agencies will notify the Arkansas State Board of Pharmacy.

Fields to be completed on the Fingerprint Card

(Type or print, black ink only - Fingerprints must be done in **BLACK** Ink.)

- Last name, First name, Middle name
- Signature of person fingerprinted – be sure to sign this field in front of the fingerprint technician
- Aliases (other names you have used, including nicknames, maiden names, other married names, etc.)
- Date of birth (MM/DD/YYYY)
- Residence of person fingerprinted (street address or post office box, city, state, zip)
- Citizenship (i.e., United States, England, Mexico)
- Sex: M= Male, F= Female
- Race: A=Asian; W=White; B=Black; I=American Indian, H=Hispanic, U=Unknown
- Height (foot' inches")
- Weight (in pounds)
- Eyes: BLU=Blue; BRO=Brown; BLK=Black; GRY=Gray; GRN=Green; HAZ=Hazel; XXX=Unknown
- Hair: BAL=Bald; BRO=Brown; BLK=Black; SDY=Sandy; GRY=Gray; WHI=White; BLN=Blond; RED=Red; XXX=Unknown
- Place of birth (city/state or foreign country)
- Employer and address ("none" if you are unemployed)
- Reason Fingerprinted - **This block MUST read: Arkansas State Board of Pharmacy – ACA § 17-92-317**
- Social Security Number
- Leave all other spaces blank (i.e., OCA, FBI, MNU)
- If an individual is missing one or more fingers, a notation in the fingerprint block(s) indicating why a partial or missing image exists must be written in. Handwritten notation recommended for fingerprint submissions include: AMP=amputated; TI=tip amputated; Missing at Birth; Cut off; Shot off; Deformed; and Missing.

Arkansas State Board of Pharmacy

322 South Main Street, Suite 600 Little Rock, AR 72201

P: 501.682.0190 F: 501.682.0195

asbp@arkansas.gov • www.pharmacyboard.arkansas.gov

John Clay Kirtley, Pharm.D., Executive Director

Criminal Background Check Identity Verification Form

FINGERPRINT REASON: **Authority:** ACA § 17-92-317 **Agency ID:** AR 920450Z
Agency Name: ST BD OF PHARMACY, LITTLE ROCK, AR

APPLICANT INFORMATION (Please fill out all the fields below BEFORE going to be fingerprinted):

Full Name:

Last | First | Middle | Maiden / All Other Married Names

Social Security #: Date of Birth: State of Birth:

Sex: Race: Height: Weight: Eyes: Hair:

Driver's License #: State of Issuance (of driver's license):

Mailing Address:

Street Address | City | State | Zip

I understand that my personal information and fingerprints submitted by agency are used to search against criminal identification records from both Arkansas Crime Information Center (ACIC) and Federal Bureau of Investigation (FBI). I hereby authorize the release of any records to the person or agency listed above. I further understand ACIC and the FBI may also retain the submitted information and fingerprints as permitted by the Privacy Act of 1974, 5 USC § 552a, for routine uses beyond the principal purpose listed above.

Signature of Applicant | Date

ATTENTION FINGERPRINT TECHNICIAN: Please follow the instructions below for fingerprinting this applicant.

1. Please ensure that the applicant has filled out all the information on the fingerprint card and the information below for "APPLICANT INFORMATION" prior to taking the fingerprints.
2. Request a valid, unexpired government-issued photo ID from the applicant and compare the physical descriptors on the applicant's photo ID to the applicant and to the information on the fingerprint card.
3. Please fill out the information in the boxes below for "FINGERPRINT TECHNICIAN INFORMATION". Please print clearly.
4. Once the prints have been taken, make sure the applicant signs the "Signature of Person Fingerprinted" field. Place the fingerprint card and this form into the envelope and seal it. Please write your name or identification across the edge of the seal. Return the sealed envelope to the applicant. Do not give the applicant the card without first sealing it inside the envelope.

FINGERPRINT TECHNICIAN INFORMATION:

Date Fingerprints were Taken:

Type of Photo ID provided: ☐ Driver's License ☐ Passport ☐ Military ID ☐ Other:

Fingerprint Technician's Agency/Company Name:

Printed Name of Fingerprint Technician | Signature of Fingerprint Technician

** Ensure that the correct fingerprinting reason code and agency ID are used.

FOR ASBP OFFICE USE ONLY:
Envelope? Y N **Sealed?** Y N **Signed?** Y N **Completed?** Y N **Initials & Date:**

Privacy Act Statement

Privacy Act of 1974, 5 USC § 552a

This privacy act statement is also located on the back of the FD-258 fingerprint card.

- **Authority**: The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

- **Principal Purpose:** Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

- **Routine Uses:** During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

Procedure to obtain change, correction, or updating of identification records

28 CFR § 16.30 through 16.34

If, after viewing his/her identification record, the subject thereof believes that it is incorrect or incomplete in any respect and wish changes, corrections, or updating of the alleged deficiency, he/she should make application directly to the agency which contributed the questioned information.

The individual can contact Arkansas Crime Information Center (ACIC) at (501) 682-7444 or Arkansas State Police at (501) 618-8000. The subject of a record may also direct his/her challenge as to the accuracy or completeness of any entry on his/her record to the:

FBI, Criminal Justice Information Service (CJIS) Division
ATTN: SCU, Mod. D2
1000 Custer Hollow Road
Clarksburg, WV 26306

The FBI will then forward the challenge to the agency which submitted the date requesting that agency to verify or correct the challenged entry. Upon the receipt of an official communication directly from the agency which contributed the original information, the FBI CJIS Division will make any changes necessary in accordance with the information supplied by that agency.