



# 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



## **Students who will be starting at UAMS or Harding:**

Please wait to get licensing instructions directly from the school you are attending. The process of how background checks are handled in-state has changed and impacts how you apply to the Board for licensure.

## **Out-of-State Students:**

Please use the following application to apply for an intern license. If you are currently residing in the state, please contact Nancy Sweet at 501-682-0190 to discuss your options before applying. Those who are living out-of-state, please email the Board at [asbp@arkansas.gov](mailto:asbp@arkansas.gov) with your mailing address so that we can send you the Board's fingerprint card to be submitted with your completed application.



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## Intern Application Instructions

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

1. The 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. The license cannot be issued until we receive the registrar page from the College of Pharmacy.

## Supporting Documentation and Fees

Submit the following documents and fees:

1. A completed application. Please fill out in blue or black ink and make sure all the questions have been answered and the signature page has been signed.
2. A copy of your driver's license. If you do not have a driver's license, you may substitute another form of picture identification. Please contact us if you have questions about the picture ID.
3. The Criminal Background Check Identity Verification Form.  
**OUT OF STATE APPLICANTS:** [Please see the website for alternate instructions for fingerprinting.](#)
4. A check or money order made payable to the Board of Pharmacy for \$81.25. Please make sure the check or money order is in the exact amount. We do not accept cash.
5. 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 I, III and IV 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 waiver form stating the applicant's reasons why the conviction should be waived are received by the Executive Director.

**Please be sure to keep us informed if you change any of the following information:  
your name, mailing address, email address and contact telephone numbers.**



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## ARKANSAS APPLICATION FOR PHARMACY INTERN LICENSURE

**APPLICATION FEE: \$81.25**

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 IDENTIFYING INFORMATION

<b>SOCIAL SECURITY NUMBER:</b>		<b>DATE OF BIRTH:</b>	
<b>PLACE OF BIRTH</b> (city, state, county and country):			
<b>GENDER:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female			
<b>RACE:</b> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other: _____			
<b>ETHNICITY:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino			
<b>NAME: Last</b>	<b>First</b>	<b>Middle</b>	<b>Suffix (Jr.)</b>
<b>OTHER NAMES USED:</b> List any maiden name, surname, or any other aliases you have used and identify the reason for the name change.			
<b>HOME ADDRESS:</b> (Street, City, State, Zip)			
<b>MAILING ADDRESS:</b> including zip code, if different from current address listed above.			
<b>HOME PHONE #:</b> (    )		<b>CELL PHONE #:</b> (    )	
<b>EMAIL:</b>			

<b>CITIZENSHIP:</b>	a. Are you a Citizen of the United States?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	b. If you answered <b>NO</b> to question (a) above, are you: (Please check one of the following.)		
	<input type="checkbox"/> a qualified alien (as defined in 8 U.S.C. § 1641.)		
	<input type="checkbox"/> a nonimmigrant under the Immigration and Nationality Act (8 U.S.C.A. § 1101 et seq.)		
	<input type="checkbox"/> an alien who is paroled into the United States under 8 U.S.C. § 1182 (d)(5) for less than 1 year.		
	<input type="checkbox"/> other – please provide a detailed explanation.		

#### FOR OFFICE USE ONLY:

License #: PI                      Date Issued:                      Fee Paid: \$81.25                      Check No.:

## PART II: EDUCATION INFORMATION

<b>PHARMACY SCHOOL:</b>	
Are you attending pharmacy college/school in-state?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If <b>YES</b> , please indicate which one: <input type="checkbox"/> Harding University College of Pharmacy or <input type="checkbox"/> UAMS College of Pharmacy	
Is the pharmacy college/school you are attending out-of-state?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If <b>YES</b> , please list the name and city/state location of the pharmacy college/school you will be attending.	
What is your expected graduation date from pharmacy college/school?	
What is the expected start date of your APPE (senior) rotations*?	
<b>*Please note that if you are an out of state pharmacy school student, you will have to take the Arkansas State Board of Pharmacy Jurisprudence examination before starting your APPE rotations. The expiration date of your intern license will be extended to six months past the date of graduation once the ASBP Jurisprudence exam has been passed.*</b>	

**POST SECONDARY TRAINING:** List all post-secondary schools, colleges and universities attended, whether completed or not, in chronological order.

School Name	Location (City/State/Country)	Period of Attendance: (MM/YYYY)		Graduated? (Yes/No)
		From	To	

Degree(s) or Credential(s) earned:

## PART III: 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 ever been found in any civil, administrative, or criminal proceeding to have:	YES <input type="checkbox"/> NO <input type="checkbox"/>
a. Possessed, used, or distributed controlled substances or prescription drugs in any way other than for legitimate or therapeutic purposes; b. Diverted controlled substances or prescription drugs; c. Violated any state, federal, or local drug law; d. Dispensed controlled substances for yourself; e. Violated any state or federal law or rule regulating a health care profession?	
Have you ever had any certificate, license, registration or other privilege to practice a health care profession denied, revoked, suspended, restricted, reprimanded, censured, or placed on probation by a state, federal, or foreign authority or have you ever surrendered such credential in connection with or to avoid action by such authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you ever been cited, arrested for, charged with, or convicted of the commission of any crime, offense, or violation of the law in any state or by the federal government even if those charges were dismissed or expunged?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Is there any disciplinary action pending or any unresolved or pending complaints against you by any licensing jurisdiction, the USDA, Drug Enforcement Agency, or any state drug enforcement authority?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Do you currently have an alcohol or other substance abuse problem?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you currently engaged in the unlawful use of controlled substance(s)? (Unlawful use of controlled substances means the use of controlled substances obtained illegally (e.g. marijuana, meth, heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care provider.)	YES <input type="checkbox"/> NO <input type="checkbox"/>
Have you been treated for a drug or alcohol addiction, or participated in a rehabilitation program in the last 5 years?	YES <input type="checkbox"/> NO <input type="checkbox"/>

## PART IV: PHARMACY COLLEGE/SCHOOL ENROLLMENT VERIFICATION

If you are a pharmacy student, this section must be completed by the Dean or Registrar of the College or School of Pharmacy you are attending. If you are a foreign graduate, you may skip this section.

### TO BE COMPLETED BY THE DEAN OR REGISTRAR OF THE COLLEGE OR SCHOOL OF PHARMACY

I, \_\_\_\_\_ being \_\_\_\_\_ of  
(Dean or Registrar)

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a college or school of pharmacy recognized by the Arkansas State Board of Pharmacy, do hereby certify that

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(Applicant's name)

who is applying for an intern license in the state of Arkansas, is enrolled as a student prior to the first semester of the first year of professional study at this institution and is seeking a Pharm.D. degree in a four-year program of study.

Expected date of graduation is: \_\_\_\_\_  
(Year)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please affix the school seal here*

## PART V: CERTIFICATIONS

*Please read carefully and sign below.*

I understand that, as an intern, I may not perform any duties required of a pharmacist except when I am working under the direct and personal supervision of a pharmacist. I also understand that should I perform any duties which I am not licensed to perform, or should I take charge of and operate a pharmacy in the absence of a pharmacist, I am placing my ability to become a licensed pharmacist in jeopardy. I will follow all Arkansas State Board of Pharmacy laws and regulations.

I understand that if I am attending an out of state pharmacy college/school, that I will have to pass the Arkansas State Board of Pharmacy Jurisprudence Exam before I can start APPE (senior) rotations.

I understand that this license will expire six (6) months after graduation or when I receive my Arkansas (or other state) pharmacist license.

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 during my internship. 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.

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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.

### Supporting Documentation and Fees

Submit the following documents and fees with your completed application:

1. A copy of your driver's license. If you do not have a driver's license, you may substitute another form of picture identification. Please contact us if you have questions about the picture ID.
2. The Criminal Background Check Identity Verification Form. **OUT OF STATE APPLICANTS:** [Please see the website for alternate instructions for fingerprinting.](#)
3. A check or money order made payable to the Board of Pharmacy for \$81.25. Please make sure the check or money order is in the exact amount. We do not accept cash.
4. 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 I, III and IV 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 waiver form stating the applicant's reasons why the conviction should be waived are received by the Executive Director.

**Please be sure to keep us informed if you change any of the following information:  
your name, mailing address, email address and contact telephone numbers.**

**Once your license is issued, it will be mailed to the mailing address on your application.**

# Criminal Background Check (CBC) Identity Verification Form Instructions

**Please read the instructions below carefully and contact the Board with any concerns or questions. Failure to follow the correct procedures will delay the processing of your application and our receipt of your background check results.**

- Fill out all the required information on the Criminal Background Check Identity Verification (CBC) Form and submit your payment and completed application (including the CBC form) to the Board **BEFORE** going and getting fingerprinted.
- Once the Board receives and processes your application and completes the state background check, you will receive a copy of your CBC Form back via email or mail with a **Transaction Control Number** that you will need to have for your fingerprints to be taken for the federal background check. Please be sure to include an email address on your application if you have one, as this will help speed up the process of you obtaining your Transaction Control Number. **Check your email daily, including your spam folders, for an email from Board staff.** The email address will end with @arkansas.gov. The email will include an attachment of the CBC form you submitted with the addition of the Transaction Number. You will need to take this form with you when go to the electronic fingerprint harvester.
- You will take a printed copy of the CBC Form with the Transaction Control Number to an appropriately trained Fingerprint Harvester ([see our website for the most up-to-date listing](#)) to **have your fingerprints taken electronically**. They will use the Transaction Number provided by the Board to ensure that your background check results are returned to the Board. The fingerprint harvester may charge their own independent service fees to process your fingerprint submission.
- Once fingerprinted, have the person that took your prints **fill** out the “Fingerprint Harvester Information” portion of the CBC Form. They will return the form to you, and **you will be responsible for returning the CBC Form to the Board with the Harvester Information completed.** You can email, fax, or mail this completed CBC Form to the Board.

## NOTES:

- The transaction number that is provided is specific to you and is directly tied to the state background check run on your behalf by the Board. It cannot be used to run a background check for any other type of state licensure, and we cannot accept the background check results run by any other agency. Background checks must be run through the Board for Board issued licenses.
- **DO NOT CONTACT the Fingerprint Harvester, Arkansas State Police, or the FBI** about the status of your criminal background check. Those agencies will notify the Arkansas State Board of Pharmacy. The average processing time for the Board to receive the results of your background check is **three weeks** from the time that your fingerprints are submitted.
- Effective July 28, 2021, in accordance with Act 630, background checks from individuals in Arkansas must be submitted electronically (live scan). Paper fingerprint cards will no longer be accepted and will be returned to the applicant and an electronic submission will be required before the application on file with the Board can continue to be processed.
- **Out of State Applicants**: Please contact the Board for alternative fingerprinting instructions.





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## Criminal Background Check (CBC) Identity Verification Form

### APPLICANT INFORMATION

**(Please fill out all the fields below and send to the Board 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 HARVESTER: Please follow the instructions below for fingerprinting this applicant.

1. 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 the information above.
2. Please fill out the information in the boxes below for "FINGERPRINT HARVESTER INFORMATION". Please print clearly. Please return completed form to the applicant to return to the Board.

### FINGERPRINT HARVESTER INFORMATION:

REASON FINGERPRINTED: (RFP)

Authority:

ACA § 17-92-317

Agency ID:

AR 920450Z

Agency Name:

ST BD OF PHARMACY, LITTLE ROCK, AR

TRANSACTION CONTROL NUMBER:  
(Confirmation Number)

**PHB**

Date Fingerprints were Taken:

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

Harvester Facility Name:

Harvester Operator Telephone Number:

Printed Name of Harvester Operator

Signature of Harvester Operator

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



# Privacy Act Statement

Privacy Act of 1974, 5 USC § 552a

- **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.