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 with your mailing address so that we can sent 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. A completed and signed Criminal Background Check Identity Verification Form.

4. A completed fingerprint card – if you need a fingerprint card to have your fingerprints taken, please contact the Board with your mailing address. You can contact the Board at asbp@arkansas.gov or at 501-682-0190.

5. A check or money order made payable to the Board of Pharmacy for $80. Please make sure the check or money order is in the exact amount. We do not accept cash.

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 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 wavier 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

OUT OF STATE APPLICANT APPLICATION FEE: $80

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

SOCIAL SECURITY NUMBER:	**DATE OF BIRTH:**
PLACE OF BIRTH (city, state, county and country)**:**	
GENDER: ☐ 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: List any maiden name, surname, or any other aliases you have used and identify the reason for the name change.			
HOME ADDRESS: (Street, City, State, Zip)			
MAILING ADDRESS: including zip code, if different from current address listed above.			
HOME PHONE #: ( )		**CELL PHONE #: ( )**	
EMAIL:			

CITIZENSHIP:

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

b. If you answered **NO** to question (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 1 year.
- ☐ other – please provide a detailed explanation.

FOR OFFICE USE ONLY:

License #: PI Date Issued: Fee Paid: $80 Check No.:

PART II: EDUCATION INFORMATION

PHARMACY SCHOOL:

Are you attending pharmacy college/school in-state? YES ☐ NO ☐

If **YES**, please indicate which one: ☐ Harding University College of Pharmacy or ☐ UAMS College of Pharmacy

Is the pharmacy college/school you are attending out-of-state? YES ☐ NO ☐

If **YES**, 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*?

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.

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 ☐ NO ☐

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 ☐ NO ☐

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 ☐ NO ☐

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 ☐ NO ☐

Do you currently have an alcohol or other substance abuse problem? YES ☐ NO ☐

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 ☐ NO ☐

Have you been treated for a drug or alcohol addiction or participated in a rehabilitation program in the last 5 years? YES ☐ NO ☐

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)

_____

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

_____
(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 in 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.

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. A completed and signed Criminal Background Check Identity Verification Form.

3. A completed and signed Fingerprint Card.

4. A check or money order made payable to the Board of Pharmacy for $80. 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 wavier 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 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:

- **Fingerprint cards are required for out-of-state applicants.** In-state applicants must use the In-State CBC Form to have their fingerprints electronically harvested. 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. The State of Arkansas is not currently set up to receive electronic fingerprint submissions from out-of-state locations.

- **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. Contact your city's police station or the county sheriff's office to see if they can fingerprint you. There are also independent live scan operators that may be able to fingerprint you, however, make sure they can print your fingerprints on the FBI fingerprint card provided by the Board.

- **DO NOT BEND OR FOLD THE FBI FINGERPRINT CARD.**

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 – sign this field in front of the fingerprint technician after they've verified your identity
- 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)
- Social Security Number
- Leave all other spaces blank (i.e., Reason Fingerprinted, 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.

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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 and that you have signed the "Signature of Official Taking Fingerprints" 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.