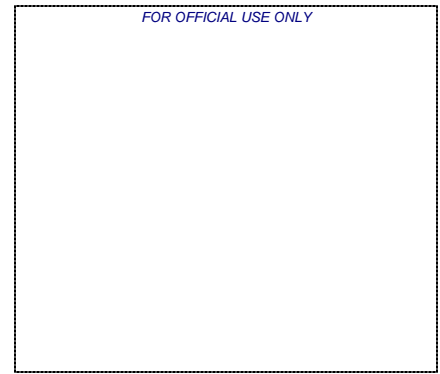
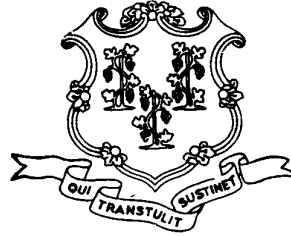


STATE OF CONNECTICUT
 Department of Consumer Protection
 COMMISSION OF PHARMACY
 165 Capitol Avenue, Room 147
 Hartford, CT 06106
 Telephone: (860) 713-6070
 Web Site: www.ct.gov/dcp



APPLICATION FOR LICENSURE AS A PHARMACIST BY EXAMINATION

This application should be completed and returned with payment to:
DCP, License Services Division, 165 Capitol Ave., Hartford, CT 06106

• Section I: Examination

Please "CHECK" the box on the left below:

I am applying for licensure as a pharmacist in the State of CT and am submitting a check/money order for **\$200.00** for this purpose, made payable to 'Treasurer, State of Connecticut.'

IMPORTANT NOTICE: You are required to pass both the NAPLEX and MPJE (for CT) Exams that are administered through the National Association of Boards of Pharmacy before you can be licensed as a pharmacist in Connecticut.

• Section II: Personal information

First Name	Middle Initial	Last Name	
Residence Street Address	City	State	Zip Code
Telephone Number (with area code)	Email Address		
Social Security Number	Date of Birth	Place of Birth (City & State)	

• Section III: Pharmacy Education

Colleges Attended	Dates attended	
College name	From	To
College name	From	To
College name	From	To

I was granted a diploma of graduation from (Name of college) _____
 on the ____ day of _____, _____, and received the degree of: _____
 (Month) (Year) (Type of Degree)

• **Section IV: Practical Experience/Intern Registration**

I have a total of (number) _____ hours of practical experience on file with the (State) _____ Board of Pharmacy.

Please check the appropriate statement(s):

My internship hours are on file with the Connecticut Commission of Pharmacy since I hold a pharmacy intern registration issued by the State of Connecticut.

Registration number	Date of issue	Expiration date
---------------------	---------------	-----------------

My internship hours are not on file with the Connecticut Commission of Pharmacy and **I will request that my State Board of Pharmacy or College of Pharmacy send the hours directly to the Connecticut Commission of Pharmacy.**

• **Section V: Previous Licensure as a Pharmacist**

If you have previously been licensed as a pharmacist in this state or any other state please complete the following:

Name of State	Date(s) issued: (month/yr)	License number	Good standing <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of State	Date(s) issued: (month/yr)	License number	Good standing <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of State	Date(s) issued: (month/yr)	License number	Good standing <input type="checkbox"/> Yes <input type="checkbox"/> No

• **Section VI: Additional Qualifications**

- ◆ I will be 18 years of age at the anticipated time of my licensure in CT as required by law: **Yes** **No**
- ◆ I have submitted a recent photograph of myself (no less than 2" x 3", frontal view) and I have signed it on the front or back as required by the Commission **Yes** **No**

• **Section VII: Certification**

I CERTIFY, UNDER PENALTY OF LAW THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS THE TRUE TO THE BEST OF MY KNOWLEDGE.

Signature: _____

Date: _____

• **Section VIII: Affidavit of Educational Institution**
To be completed by school or college of pharmacy

For Graduates of an Accredited College of Pharmacy Only

This is to certify that (student's name) _____ has attended the _____ from ____/____/____ to ____/____/____
 Name of College of Pharmacy Mo. Day Yr. Mo. Day Yr.
 Date (or expected) of Graduation: _____ Degree (to be) received: _____

Certified By: _____
 Print Name of Dean/Registrar Signature Dean/Registrar

School Seal: (apply here)

