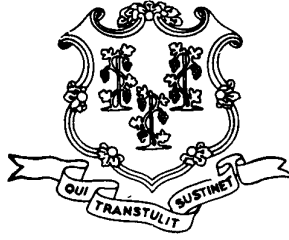


CPPCT-01, REV 05/13
 STATE OF CONNECTICUT
 Department of Consumer Protection
 COMMISSION OF PHARMACY
 165 Capitol Avenue, Room 147
 Hartford, CT 06106
 Telephone: (860) 713-6070
 Web Site: www.ct.gov/dcp/dcd
 Email: DCP.PharmacistLicense@ct.gov



FOR OFFICIAL USE ONLY

APPLICATION FOR LICENSURE AS A PHARMACIST BY EXAMINATION

This application should be completed and returned with payment to:

**Department of Consumer Protection
 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)		

"The Federal Privacy Act of 1974 requires that you be notified that disclosure of your Social Security Number is required pursuant to C.G.S. §17b-137a. If you choose not to disclose your Social Security Number your application cannot be processed."

• **Section III: Pharmacy Education**

College(s) 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**

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
---------------------	---------------	-----------------

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

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 (passport size, frontal view) and I have signed it on the front or back as required by the Commission Yes No
- ◆ Has the applicant ever been convicted of any criminal charge under Federal or State controlled drug laws?
 Yes No **If yes, attach a statement of explanation.**
- ◆ Has any Federal or State registration held by the applicant been surrendered, revoked, suspended, limited, denied or is any such action pending? Yes No **If yes, attach a statement of explanation.**

• **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)

