



OKLAHOMA STATE BOARD OF PHARMACY

2920 N Lincoln Blvd, Suite A, Oklahoma City, OK 73105
Phone: (405) 521-3815 / Fax: (405) 521-3758
www.pharmacy.ok.gov / e-mail: pharmacy@pharmacy.ok.gov

FOR OSBP USE ONLY		
RECEIPT:		AFFIDAVIT__
DATE:		

2016-2017 NOTICE OF RENEWAL OF PHARMACIST LICENSE

License No. _____

Please PRINT clearly

Fee doubles 15 days after expiration

EXPIRES: _____

Name _____

Address _____

City, State, Zip _____

[check all that apply]

FEES:

Active/Inactive - **\$100**

Sr. Inactive - **\$20**

Preceptor - **\$10**

Section I. Renewal (expires last day of birth month)

✓ Check all that apply:

- I request **Active** renewal of for a fee of **\$100.00**. I certify that I have obtained **fifteen (15) clock hours** of continuing education credits through satisfactory completion of an accredited program **during the previous calendar year (i.e. Jan-Dec 2015)** as stated in Section VI.
- I request **Inactive** renewal for a fee of **\$100.00**. I understand that I may not practice pharmacy in Oklahoma while Inactive. I am NOT required to complete CE.
- I am **retired and age 65 or over**. I request **Senior Inactive** renewal for a fee of **\$20.00**. I understand that I may not practice pharmacy in Oklahoma while Senior Inactive. I am NOT required to complete CE.
- I am currently a licensed **PRECEPTOR**. I request renewal of my preceptor permit for a fee of **\$10.00**. I understand that my preceptor permit expires annually at the same time as my pharmacist license.

PLEASE ALLOW 3 WEEKS FROM DATE OF RECEIPT FOR PROCESSING.

Section II. Contact Information

Home Phone: _____ Cell Phone: _____ Home e-mail: _____

Section III. Current Employment (see Section VII for additional employment or attach separate page if necessary)

Primary Place of Employment: _____

Employer's Address _____

Date of employment (mo/yr) _____ Employer's OK Phcy Lic # _____ Full-Time Part-Time

Work Phone: _____ Work Fax: _____ Work e-mail: _____

Section IV. Practice (practice information to be answered for your primary employment)

- CHAIN INDEPENDENT HOSPITAL LONG TERM CARE RELIEF
- EDUCATION GOVERNMENT OTHER _____

Are you currently practicing pharmacy in Oklahoma? ___ YES ___ NO

Section V. Charges and Convictions (✓one)

I ___ HAVE ___ HAVE NOT been the subject of a disciplinary action or other action by any other licensure Board in this state or any other state, or been arrested, charged, indicted, or convicted, or received a deferred sentence for any misdemeanor or felony offense since my last renewal or within the last 24 months.

If you HAVE, you must complete an 'Addendum to Application with Charges & Convictions' form and attach to this application. The addendum form may be found at: http://www.ok.gov/OSBP/Forms_for_Download/Pharmacists/index.html.

Section VI. Continuing Education *(attach separate page if needed)*

- (1) List below 15 clock hours of CE obtained in the **previous calendar year (i.e. Jan-Dec 2015)**. CE verification forms are to be maintained by the pharmacist signing below for a period of two years from the date this renewal is submitted.
- (2) **New graduates are NOT exempt from reporting continuing education and must list the following:**
 - (a) **Name of Program:** the name of the pharmacy school attended during the **previous calendar year (i.e. 2015)**
 - (b) **Completion Date:** the dates enrolled in pharmacy school during previous calendar year (e.g. Jan-May 2015, etc.)
 - (c) **# Hours:** 15.
- (3) If you completed a program that was **Board approved but not ACPE approved**, please **list the name of sponsor or OSBP CE Approval #** in the ACPE column.
- (4) If you attended a **live program**, the completion date is the date that you attended the program.
- (5) If you participated in a **correspondence/online course**, these courses are not complete until you receive a certificate of completion from the provider. The following dates are accepted:
 - Activity/Program date
 - Statement/Certificate issue date
 - Authorized Signature date

Name of Program	ACPE Number	Completion Date (mo/yr)	Live? √	# Hours
(continue on separate sheet if necessary)				TOTAL:

Section VII. Additional Employment

Employment #2: _____

Employer's Address _____

Date of employment (mo/yr) _____ Employer's OK Phcy Lic # _____ Full-Time Part-Time

Phone: _____ Fax: _____ work e-mail address: _____

Employment #3: _____

Employer's Address _____

Date of employment (mo/yr) _____ Employer's OK Phcy Lic # _____ Full-Time Part-Time

Phone: _____ Fax: _____ work e-mail address: _____

Section VIII. Swear and Affirm

I SUBSCRIBE TO THE RULES OF PROFESSIONAL CONDUCT.

I swear and affirm under penalty of perjury pursuant to Title 21 O.S. 491 and/or discipline by the Board of Pharmacy under the pharmacy laws and rules of the State of Oklahoma that all information I have supplied herein is true and complete.

Signature _____ **Date** _____