OKLAHOMA STATE BOARD OF PHARMACY
4545 Lincoln Blvd., Suite 112, Oklahoma City, OK 73105-3413
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:		

2012-2013 NOTICE OF RENEWAL OF PHARMACIST LICENSE

License No. ____________ Please PRINT clearly

Name ________________________________

Address ________________________________

City, State, Zip ________________________________

Fee doubles 15 days after expiration
EXPIRES:________________

[√ 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. 2011)** 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 will expire annually at the same time as my pharmacist license.

PLEASE ALLOW A MINIMUM OF 21 DAYS FROM DATE OF RECEIPT FOR PROCESSING.

Section II. Contact Information

Home Phone: ______________ Cell Phone: ____________ Home e-mail: ________________________

Section III. Current Employment *(see pg 2 for additional employment or attach separate sheet 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

I ☐ **HAVE** ☐ **HAVE NOT** been the subject of a disciplinary action by any other licensure Board in this state or any other state, or been arrested, charged 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, state details on a separate addendum and attach to this application.

ANY CERTIFICATE NOT RENEWED IS SUBJECT TO CANCELLATION 30 DAYS AFTER EXPIRATION

Section VI. Continuing Education

(1) List below 15 clock hours of CE obtained in the **previous calendar year (i.e. 2011)**. CE verification forms are to be maintained by the pharmacist for a period of two years from this date.

(2) If you attended a ***live program***, the completion date is the date that you attended the program.

(3) If you participated in a ***correspondence course***, these courses are not complete until you receive a certificate of completion from the provider. The following dates are accepted:

- Date of authorized signature
- Date issued / earned
- Date exam processed

(4) If you completed a program that was ***Board approved but not ACPE approved***, please ***list the sponsor*** in the ACPE column.

(5) ***New graduates are <u>NOT</u> exempt from reporting continuing education.*** Please list the following: (1) Name of Program: the name of the school you attended during the previous calendar year (i.e. 2011); (2) Completion Date: the dates you attended school (e.g. Jan-May 2011, Jan-Dec 2011, etc.); and (3) # (clock) Hours: 15.

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 to the best of my knowledge and belief.

Signature ______________________________ **Date** __________

ANY CERTIFICATE NOT RENEWED IS SUBJECT TO CANCELLATION 30 DAYS AFTER EXPIRATION