Washington State Board of Pharmacy
PO Box 1099
Olympia, WA 98504-1099
360.236.4700

Pharmacy Assistant Application Packet

Contents:

1. 690-133 .. Contents List/SSN Information ....1 page
2. 690-157 .. General Instructions Checklist ....1 page
3. 690-100 .. Application For Pharmacy Assistant ....4 pages
4. RCW Links, AIDS Courses, Online Web Sites, Required Hours Of Training ......1 page

Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application.

If you do not have a social security number at the time you send in this application, please contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Return Completed Applications to: (No fee required)

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send additional documents to:

Customer Service Center
P.O. Box 47865
Olympia, WA 98504-7865
360.236.4700

Washington State Board of Pharmacy
PO Box 1099
Olympia, WA 98504-1099
360.236.4700

General Instructions Checklist

☐ **#1: Demographic Information:**

Social Security Number: You are required by state and federal law to provide a social security number with your application.

If you do not have a social security number at the time you send in this application, please contact the Customer Service Center at 360.236.4700 for more information.
Name: Please list your current name with middle initial.

Residential Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

Telephone Number: Enter current number where you may be reached during normal business hours.

☐ **#2: Personal Data Questions:**
All applicants for certification are required to answer the same personal data questions. These are narrowly focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation and the documentation listed in the note following the question. If you do not provide the documents, your application is incomplete and your application will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- For question 5, you must answer yes if you were convicted as either a juvenile or an adult. The question includes misdemeanors, gross misdemeanors and felonies. "Another jurisdiction" means any other country, state, federal territory, or military authority.

☐ **#3: AIDS Education and Training Attestation:**
AIDS affidavit must be initialed and dated. AIDS training may include self-study, direct patent care, courses, or formal training, required by **WAC 246-12-060** course content can be found at **WAC 246-12-270**.

☐ **#4: Applicant's Attestation:**
You must sign and date this for us to process the application. Read thoroughly to ensure you understand the provisions in this section.

☐ **#5: Applicant's Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up, and a front view. Your application will not be processed without a current photograph.

Washington State Board of Pharmacy
PO Box 1099
Olympia, WA 98504-1099
360.236.4700

Background Check Stamp Here

Date Stamp Here

Revenue: 1A 026201000 00787

Application for Pharmacy Assistant

No fee required

Please type or print clearly. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. Make sure you have read and understand the instructions.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

— —

Name ☐ Mr. ☐ Ms. First Middle Last

Birth date (MM/DD/YYYY)	Place of birth		
	City	State	Country

Address

City	State	Zip	County

Country

Mailing address if different from above

City	State	Zip	County

Country

Phone ( )	Fax ( )	Cell ( )

Email address:

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

Issuance Date ____________________ License # ____________________

Validation ____________________ Received Date ____________________

2. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach an explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

> Note: **If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

> Note: **If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile, in Washington or another state or jurisdiction? ☐ ☐

> Note: **If you answered yes, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and your application will not be considered.**
>
> **To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

2. Personal Data Questions (cont.)

YES NO

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .... ☐ ☐
   b. Diverted controlled substances or legend drugs? .... ☐ ☐
   c. Violated any drug law? .... ☐ ☐
   d. Prescribed controlled substances for yourself? .... ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .... ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .... ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .... ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .... ☐ ☐

3. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

4. Applicant's Attestation

I, _________________________________, declare under penalty of perjury under the laws of the state of
(Print applicant name clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read RCW 18.130.170 and RCW 18.130.180 of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated __________________in __________________________ (city, state)

By:_________________________________
Signature of applicant

5. Applicant's Photograph

Photo Here

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

Washington State Board of Pharmacy
PO Box 1099
Olympia, WA 98504-1099
360.236.4700

Health Professions Reference Numbers and Links

RCW Links

UDA RCW 18.30 ....Uniform Disciplinary Act

APA RCW 34.05 .... Administrative Procedure Act

WAC 246-12 .... Administrative procedures and requirements

AIDS Courses

Health Impact .... 1.800.783.2437 *or* 206.284.3865

W.F. Professional 1.800.323.4305

AIDS Resources 206.784.5655

Red Cross offers AIDS classes.
You can also contact your local health department.

On-Line

AIDS Training .... http://www.doh.wa.gov/cfh/HIV_AIDS/Prev_Edu/training.htm

Pharmacy Board https://fortress.wa.gov/doh/hpqa1/hps4/Pharmacy/default.htm

Required Hours of Training

Pharmacist .... 7 hours

Technician .... 4 hours

Assistant .... 4 hours