

# MISSISSIPPI BOARD OF PHARMACY

8582'K77'PQTVJ , SUITE 622: LCEMSON, MS 39411  
601-; ; -88: 2: Fax 601-; ; -: : 73



## INSTRUCTION SHEET AND CHECKLIST FOR APPLICANTS FOR PHARMACIST LICENSURE - TRANSFER

PLEASE FOLLOW INSTRUCTIONS EXACTLY – FAILURE TO FOLLOW INSTRUCTIONS MAY LENGTHEN THE PROCESSING TIME OR RESULT IN RETURN OF THE PACKET TO YOU. **The first three steps MUST be completed before any of the attached applications should be filled out. Call us if there is a question about the process.**

**NOTE: The MPJE exam is required by the Mississippi Board of Pharmacy.** You may take this test through NABP at any time during the process.

- PRELIMINARY APPLICATION MUST BE OBTAINED THROUGH – [WWW.NABP.NET](http://WWW.NABP.NET). Transferee will complete the application and return it to NABP.
- NABP will notify the Mississippi Board of the Transfer request after they process the preliminary application.
- NABP will then send the transferee an official application (allow 3-6 weeks) to be completed by transferee and returned to the Mississippi Board of Pharmacy within 90 days along with a **\$200** money order for transfer fees.  
**\*\*\*THE ABOVE STEPS MUST BE COMPLETED BEFORE THE FOLLOWING\*\*\***
- If you plan to dispense controlled substances in the state of Mississippi, you must apply for a controlled substance registration. This application is attached. In addition, the affidavit questionnaire must be completed and notarized (Pages 1- 2).
- Place the Controlled Substance Registration Application and Affidavit Questionnaire (Pages 1 and 2) AND additional fees (**\$50 for controlled substance registration and \$40 background check fee**) in a postage paid envelope (not included) and take it with you (along with page 3 and the fingerprint card) to be fingerprinted.
- You must use the blue and white FD-258 fingerprint card (not provided) to be fingerprinted by the agency of your choice (local police, sheriff, department of public safety, human resources, etc). You are responsible for any fees associated with the fingerprinting. **The verification form must be completed by the person taking the fingerprints** (Page 3). If the agency does not have the FD-258 card, please call the Board and we will send one to you.
- Ask the person who took the fingerprints to place the completed fingerprint card and verification form (Page 3) in the return envelope (provided by you) along with the affidavit questionnaire and controlled substance registration (Pages 1 and 2) and fees. Have them seal the envelope and drop it in the mail to our office.**

**IMPORTANT:** If you have EVER been arrested, you MUST answer YES on the questionnaire and include an explanation. Falsification of your application for registration (including partial falsification and/or giving information that is misleading) constitutes grounds for IMMEDIATE DENIAL of your application to obtain a license/registration with the Board of Pharmacy. Information will be verified.

Address

8582 K77"P qtj  
Suite 622  
Icenson, MS 39211  
Office: 601-899-8880  
Fax: 601-899-8851

# MISSISSIPPI BOARD OF PHARMACY



## APPLICATION FOR REGISTRATION TO HANDLE CONTROLLED SUBSTANCES ----FEE \$50.00

*If issued in the first half of the annual registration period (January 1 – June 30), the registration will expire at the end of the current registration period. If issued in the second half of the registration period (July 1 -- December 31), the registration will be valid through the next registration period. See back of card for expiration date.*

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_

County: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_  
(Name of Business)

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Work Phone: \_\_\_\_\_

The attached \$50.00 is payment for registration with the Mississippi Board of Pharmacy to dispense controlled substances as indicated below. (This registration must be renewed **annually**.)

Drug Schedules Which Will Be Dispensed: (check all applicable)

- |  |  |
|--|--|
| <input type="checkbox"/> Schedule II Narcotic  | <input type="checkbox"/> Schedule II Non-Narcotic  |
| <input type="checkbox"/> Schedule III Narcotic | <input type="checkbox"/> Schedule III Non-Narcotic |
| <input type="checkbox"/> Schedule IV (all)     | <input type="checkbox"/> Schedule V (all)          |

Signature: \_\_\_\_\_

Name (Printed or Typed): \_\_\_\_\_

Date: \_\_\_\_\_

### OFFICE USE ONLY

REGISTRATION NUMBER \_\_\_\_\_

FILE NUMBER: \_\_\_\_\_

DATE ISSUED: \_\_\_\_\_

RECEIPT NUMBER \_\_\_\_\_

# MISSISSIPPI BOARD OF PHARMACY

6360 I-55 North, Suite 400, Jackson, MS 39211

## Affidavit Questionnaire

This form, completed and signed, will be maintained in your permanent file in the office of the Mississippi Board of Pharmacy. **Any omissions, or answers / explanations later found to be false or deceptive, could result in the Board denying issuance of or taking action against your license/registration in the State of Mississippi.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN#: \_\_\_\_\_ Nickname: \_\_\_\_\_

Answer yes or no to the following questions. **Any question answered Yes must have a full and complete explanation attached (typed or computer printed).**

1. Have you ever held a license/registration in any other profession? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. Was that license/registration ever surrendered, resigned, canceled, or denied reissuance? \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Have you ever been licensed/registered under any other name by any Board or licensing authority? \_\_\_\_\_ Yes \_\_\_\_\_ No
4. Has action of any type ever been taken against any license/registration? \_\_\_\_\_ Yes \_\_\_\_\_ No
5. Have you ever failed to pass any state board or national board examination? \_\_\_\_\_ Yes \_\_\_\_\_ No
6. Have you ever been arrested? \_\_\_\_\_ Yes \_\_\_\_\_ No
7. What were the results of that arrest(s)? Explain on attached page as required above.
8. Do you have any felony or misdemeanor charges pending against you? \_\_\_\_\_ Yes \_\_\_\_\_ No
9. Have you ever been convicted of a felony or misdemeanor? \_\_\_\_\_ Yes \_\_\_\_\_ No
10. Have you ever used controlled substances or prescription drugs recreationally or without a valid prescription? \_\_\_\_\_ Yes \_\_\_\_\_ No
11. Have you ever received inpatient or outpatient treatment for alcohol or drug abuse? \_\_\_\_\_ Yes \_\_\_\_\_ No

**ANY OMISSIONS, FALSE AND/OR MISLEADING ANSWERS, OR FALSE AND/OR MISLEADING EXPLANATIONS, MAY RESULT IN DENYING ISSUANCE OF, OR TAKING ACTION AGAINST, YOUR LICENSE/REGISTRATION IN THE STATE OF MISSISSIPPI.**

### AFFIDAVIT OF APPLICANT

I, the above-named applicant, state, under oath, that I am the person referred to in this questionnaire and that all the statements herein contained are each and all strictly true in every respect. I understand that false or forged statements made in connection with this questionnaire may be grounds for the Mississippi Board of Pharmacy to refuse to issue or renew, suspend, restrict, revoke or take other disciplinary action against my license/registration in the State of Mississippi. I understand that if I am issued a license/registration, failure to comply with the laws or regulations governing the practice of pharmacy of this state, or any other state, will be cause for disciplinary action by the Mississippi Board of Pharmacy.

Further, that I give my consent for the release to the Mississippi Board of Pharmacy of any and all records or any other information which may relate to the above questions or my practice from any source or jurisdiction.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Printed Name

Sworn to before me and subscribed in my presence this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

(Seal)

\_\_\_\_\_  
Notary Public

My Commission Expires \_\_\_\_\_

# **MISSISSIPPI BOARD OF PHARMACY**

6360 I-55 NORTH, SUITE 400 : JACKSON, MS 39211  
601-899-8880 : Fax 601-899-8851



PER FBI REQUEST, DO NOT RETURN COMPLETED FINGERPRINT CARD TO APPLICANT

## **FINGERPRINT VERIFICATION** **MUST BE COMPLETED BY PERSON TAKING FINGERPRINTS**

The enclosed fingerprint card contains the prints of the following individual:

---

(Applicant Name)

and were taken by:

Official's Name Printed: \_\_\_\_\_

Signed: \_\_\_\_\_

Title: \_\_\_\_\_

Agency: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date: \_\_\_\_\_

Individual fingerprinted was identified by:

\_\_\_\_\_ Driver's License Photo

\_\_\_\_\_ Other Photo Identification (list type) \_\_\_\_\_

\_\_\_\_\_ Person is known personally to me

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**THE PERSON TAKING THE PRINTS SHOULD PLACE THIS VERIFICATION FORM AND FINGERPRINT CARD, ALONG WITH THE COMPLETED APPLICATION, IN A POSTAGE PAID ENVELOPE (supplied by applicant) AND RETURN IT TO THE MISSISSIPPI BOARD OF PHARMACY.**