# VIRGIN ISLANDS BOARD OF PHARMACY

**- 0 -**

***Department of Health***
***PO Box 222995***
***Christiansted, VI 00822-2995***
***Tel: 340-718-1311 xt 3849 STX***

To Whom It May Concern:

Thank you for your recent request for information regarding licensure for the Practice of Pharmacy in the U.S. Virgin Islands.

The Virgin Islands Board of Pharmacy is now an active member of the National Association of Boards of Pharmacy (NABP). As such, we are also a member of the Licensure Transfer Program. Since you are licensed in another state(s) you can access the NABP website at **www.napb.net** for the application for Licensure Transfer. Once the application has been cleared by NABP, the Board will make its final decision and inform you.

You are also required to complete and submit our Pharmacy application, which is enclosed. If you have any questions, you may contact the Board at the above numbers.

Thank you for your interest.

Sincerely,

Danson Nganga, PharmD.
Secretary, V.I. Board of Pharmacy

Enclosure

# VIRGIN ISLANDS BOARD OF PHARMACY

## APPLICATION FOR PHARMACIST LICENSE

**A non-refundable application fee of $25.00 (check or money order) is required with application.**

**NOTE**

**ANY FALSE OR MISLEADING INFORMATION IN CONNECTION WITH THIS APPLICATION MAYBE CAUSE FOR DEBARMENT ON THE GROUND OF LACK OF GOOD MORAL CHARACTER.**

**AFFIX**
**PHOTO**
**HERE**

_____

I hereby apply for licensure to practice Pharmacy in the U.S. Virgin Islands, in accordance with the terms set forth in Section 149 of Act 1714 - an Act to regulate the practice of Pharmacy in the U.S. Virgin Islands and other purposes.

**E-mail:**_____

**Full Name:** _____ **Phone:** _____

**Mailing Address:** _____

_____

**Date of Birth:** _____ **Place of Birth:** _____

**Citizenship:** _____ **Last 4 Digits S.S.#**_____

**Father's Name:** _____ **Mother's Name:** _____

**Place of expected employment on Island:** _____
(if applicable)

**PHARMACY COLLEGE TRAINING:**

I was granted a diploma of graduation from _____

_____ on the _____ day of _____ _____, the

_____ degree being thereby conferred.

**PRACTICAL EXPERIENCE:**

List work experience on resume to include, begin with present or last position held: Name of agency, address of agency, position held, responsibilities, supervisor, period of employment, reason for leaving.

**REFERENCES: (One Personal and Two Professional)**

| Name | Address/Tele. No. |
|---|---|
| _____ | _____ |
| | _____ |
| | _____ |
| _____ | _____ |
| | _____ |
| | _____ |
| _____ | _____ |
| | _____ |
| | _____ |

**LICENSURE RECORD:**

I am presently registered and in good standing in the following States:

| State | License # | Date Acquired | Expiration Date |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

(Enclose copies of licenses with application, and mail Verification Form to all State Board)

**HAVE YOU EVER BEEN CHARGED, CONVICTED OF ANY FELONY, FINED, REPRIMANDED, YOUR EMPLOYMENT TERMINATED FOR VIOLATION OF PHARMACY, LIQUOR OR NARCOTIC LAWS, OR AS SUCH PENDING? Yes _____ No _____**

If **Yes**, explain _____

_____

_____

**I, _____, DO SOLEMNLY SWEAR AND AFFIRM THAT I HAVE PERSONALLY COMPLETED THIS FORM AND THE INFORMATION IN THE FOREGOING PARAGRAPHS AND THE DOCUMENTS SUBMITTED ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.**

_____

***(Applicant sign name in full)***

***Subscribed and Sworn to, before me, this _____ Day of _____ A.D. _____***

_____

***(Notary Public)***

***My Commission Expires*** _____

## REQUIREMENTS FOR LICENSURE AS A PHARMACIST IN THE VIRGIN ISLANDS

1. Submit application as prescribed by and obtained by the V.I. Board of Pharmacy along with all requested documents. **NOTE:** Any false or misleading information in connection with this application may be cause for debarment on the ground of Good Moral Character.

2. Submit a recent un-mounted photograph of passport size of himself/herself autographed across the back and dated.

3. Submit a chronological account of all time spent between the date of graduation from your pharmacy school and time of application.

4. Submit a copy of diploma/degree from a School or College of Pharmacy accredited by the American Council on Pharmaceutical Education or its successor.

5. Submit a copy of a license(s) from another state.

6. A non-refundable application fee of **$25.00** made payable to Government of the Virgin Islands.

7. Complete licensure transfer process with NABP. Website: **www.nabp.net**

8. Submit a completed and **NOTARIZED** Authorization for Release of Information.

9. If foreign-trained, proof of Foreign Pharmacy Graduate Equivalency Examination Certification (FPGEC) is required.

10. Is not unfit or unable to practice pharmacy by reason of the extent or manner of his/her use of alcoholic beverages, narcotic and/or dangerous drugs or by reason of a physical or mental disability. Submit notarized non-addiction form (in packet).

11. Be a good moral and professional character; who will properly carry out the duties and responsibilities required of a pharmacist; must be at least 21 years of age; a graduate of an ACPE accredited school of pharmacy. Submit copy of proof of age (passport or birth certificate)

12. All applicants must have passed the NABP and MJPE exam successfully in another US State or jurisdiction; In addition, non-Virgin Islands high school graduates require 1 year of active licensed experience in another US state or jurisdiction.

**NOTATIONS:**

- ❖ After reviewing your application, it may be necessary for you to take the MPJE/NAPLEX.

All applications and information for licensure should be submitted to:

***VIRGIN ISLANDS BOARD OF PHARMACY***
***Department of Health***
**PO Box 222995**
**Christiansted, V.I. 00822-2995**

## VERIFICATION OF LICENSURE

Application is requested to complete this section of the form and mail to each **State Board of Pharmacy** in which you are now or have been licensed to practice Pharmacy. You may copy this form if additional copies are needed. **State Board is to forward this form or its own verification form directly to: VI Board of Pharmacy, Department of Health, Department of Health PO Box 222995, Christiansted, V.I. 00822-2995**

TO:_____ (Name of Board)

_____
Address

I, _____, hereby authorize the _____ Board of Pharmacy to release to the Virgin Islands Board of Pharmacy any information concerning my licensure status, disciplinary records and any other information, which is material to my application for licensure. Additionally, I release your agency from liability for the release of such information to the V.I. Board of Pharmacy in good faith.

_____ _____
Applicant Signature Date

Address_____

My License No. in your State: _____ Exp. Date: _____

**THIS SECTION IS TO BE COMPLETED AND SIGNED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE VI BOARD OF PHARMACY AT THE ABOVE ADDRESS.**

Name of State Board: _____
Full Name of Licensee: _____
License No.: _____ Issuance Date: _____ Exp. Date: _____
By: Examination/Reciprocity with the following state: _____
By: Flex Endorsement _____ National Board _____ Local State Board Examination _____

Is license current and in good standing? ___ If NO, furnish details. _____
_____
_____

Has any disciplinary action ever been taken against the above named Pharmacist? _____ If YES, furnish details
_____
_____
_____

Comments, if any: _____
_____

Signed: _____
Title: _____

**BOARD SEAL**

State Board: _____

Date: _____

# VIRGIN ISLANDS BOARD OF PHARMACY

**- 0 -**

***Department of Health of Health***
**PO Box 222995**
**Christiansted, V.I. 00822-2995**

## *AUTHORIZATION FOR RELEASE OF INFORMATION*

I, _____ hereby authorize all hospital(s), institution(s), or Organization(s) my references, employer(s) (past and present) and all Governmental Agencies and instrumentalities (local, state, federal or foreign) to release to the Virgin Islands Board of Pharmacy any information, which is needed for my licensure application.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information on this application or other information requested in relations to the application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice Pharmacy in the Territory of the United States Virgin Islands.

Additionally, I release from liability any hospital or agency releasing such information to the Board of Pharmacy in good faith.

_____ _____
Signature Date

Print Name and Address: _____

_____

_____

_____

Subscribed and sworn to before me this ____day of _____ 20____

_____
Notary Public

_____ **SEAL**
My Commission Expires

# VI DEPARTMENT OF HEALTH
# VIRGIN ISLANDS BOARD OF PHARMACY
# PO Box 222995- CHRISTIANSTED, VI 00822-2995

## NOTARIZED NON-ADDICTION AFFIDAVIT

*I, _____ am not addicted to the intemperate use of alcohol, illicit drugs, any*

(first, middle, last, suffix)

*prescription medications including controlled substances or any mind altering substances that may alter or impair my*

*judgement and ability to carry out the duties of the profession.*

**Affidavit -** NOTE: Any false or misleading information in or in connection with any application may be cause for debarment on the ground of lack of good moral character.

_____ _____

Signature Date

_____

Print Name

Subscribed and sworn to before me this _____day of _____ 20_____

_____

Notary Public

_____

My Commission Expires