



## PHARMACY TECHNICIAN REGISTRATION REQUIREMENTS

A PHARMACY TECHNICIAN is an individual who, under the direct supervision and control of a pharmacist, performs packaging, manipulative, repetitive, or other non-discretionary tasks related to the processing of a prescription in a licensed pharmacy, but excludes all functions restricted to a registered pharmacist. To work as a pharmacy technician in California, you must possess and keep current a registration as a pharmacy technician.

### HOW TO APPLY TO BECOME A PHARMACY TECHNICIAN

To be considered complete, your application must include:

1. **FEES:** A check or money order in the amount of \$80, made payable to the **Board of Pharmacy**. This is a non-refundable fee. If you reside outside California, see Fingerprint Instructions on next page for additional fees required.
2. **APPLICATION:** A pharmacy technician application (17A-5). The application must be completed in its entirety-- with all questions answered. Failure to do so will delay processing and may result in the application being returned without processing. A 2" x 2" photo must be taped to the front of the application. (Scanned images are not accepted as the images decay over time.)
3. **QUALIFYING METHOD SUBSTANTIATION:**
  - A. If you are qualifying by one of the following methods, the **Affidavit of Completion of Coursework or Graduation** portion of the application must be completed by the university, college, school or course provider.
    - ♦ An Associate degree in pharmacy technology
    - ♦ Completion of a training course accredited by the American Society of Health-System Pharmacists (ASHP);
    - ♦ Any other course that provides a minimum of 240 hours instruction as specified in section 1793.6 (c) of Title 16 of the California Code of Regulations.
    - ♦ Graduation from a school of pharmacy accredited by the American Council on Pharmaceutical Education (ACPE).
  - B. If you are qualifying by training provided by a branch of the federal armed services, you must submit the original or a certified true copy of your DD214 **with your application**. (A certified true copy is a copy that has been certified or notarized as a true copy)
  - C. If you are certified by the Pharmacy Technician Certification Board (PTCB), you must submit a certified true copy of your PTCB certificate **with your application**. (A certified true copy is a copy that has been certified or notarized as a true copy)

4. FINGERPRINT SUBMISSION (See "Fingerprint Requirements"): A copy of **Request for Live Scan Service Form** verifying that your fingerprints have been scanned and all applicable fees paid.

The board requires the applicant to have their fingerprints submitted at the time a pharmacy technician application is submitted to the board regardless of any prior fingerprint submission for other applications with the board.

A. If a California resident:

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at <http://ag.ca.gov/fingerprints/publications/contact.php>.

**Note to Applicants Submitting Fingerprints Via Live Scan:** While the Live Scan forms contained in the board's application package are pre-slugged to indicate level of service at the DOJ and FBI level, please ensure at the time of Live Scan transmission that the Live Scan operator selects both the DOJ and FBI levels of service. If FBI is not selected at the time of original transmission, you may be required to have your Live Scan redone at another time and have to repay for the DOJ and FBI levels of services again. The board has been notified by the DOJ that effective 9/1/07, if the FBI level of service is not requested at the time of original transmission both DOJ and FBI levels of service will have to be redone. Any issue of cost for resubmission should be handled at the Live Scan Site level.

B. Non California Residents:

If you reside outside California, you must submit rolled fingerprints on cards together with a fee of \$51 made payable to the Board of Pharmacy (\$32 California Department of Justice (DOJ) fee and \$19 FBI fingerprint processing fee). You may contact the board to request the fingerprint cards at (916) 574-7900. You may also request cards at [https://app.dca.ca.gov/pharmacy/pubs\\_request.asp](https://app.dca.ca.gov/pharmacy/pubs_request.asp).

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take longer than the Live Scan process, by approximately six weeks. Poor quality prints may result in rejection of the card and will substantially delay licensing since additional fingerprint cards will be required from you for processing.

**YOU MUST SATISFY ALL REQUIREMENTS FOR LICENSURE AT THE TIME OF APPLICATION.  
The application processing time for a pharmacy technician is approximately 90 days.**



**California State Board of Pharmacy**  
 1625 N. Market Blvd, Suite N219, Sacramento, CA 95834  
 Phone (916) 574-7900  
 Fax (916) 574-8618  
 www.pharmacy.ca.gov

STATE AND CONSUMERS AFFAIRS AGENCY  
 DEPARTMENT OF CONSUMER AFFAIRS  
 ARNOLD SCHWARZENEGGER, GOVERNOR

## APPLICATION FOR REGISTRATION AS A PHARMACY TECHNICIAN

**All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.** The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, (916) 574-7900, 1625 N. Market Blvd, Suite N219, Sacramento, California 95834. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Section 1798.40 of the Civil Code.

Print or type

Last Name	First Name	Middle	Former	TAPE A PHOTOGRAPH TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION  NO POLAROID	
*Address of Record: Number		Street			
City		State	Zip Code		
Residence Address: (if different from above) Number		Street			
City		State	Zip Code		
Home telephone number	Work telephone number	Date of Birth	Social Security Number**		Email Address:
( )	( )				

**Indicate below how you qualify for registration as a Pharmacy Technician:**

- Associate degree in Pharmacy Technology   
  Training Course   
  Military Training   
  Graduate of a school of pharmacy  
 Certified by PTCB - Date Certified: \_\_\_\_\_

Section 4202 of the Business and Professions Code requires an applicant for registration as a pharmacy technician to be a high school graduate or possess a general education development (GED) equivalent.

Are you a high school graduate? Yes  Date graduated \_\_\_\_\_ GED? Yes  Date GED awarded: \_\_\_\_\_

Name and location of high school \_\_\_\_\_

Name that appears on high school diploma or GED Certificate \_\_\_\_\_

(Your name needs to be included regardless of whether you have a diploma or GED.)

\*Once you are licensed with the board, the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 et seq.) and the Public Records Act (Government Code section 6250 et seq.) and will be placed on the Internet. This is where the board will mail all correspondence. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your address of record is not your residence address, you must also provide your residence address to the board, in which case your residence will not be available to the public.

**\*\* Disclosure of your U.S. social security account number is mandatory.** Section 30 of the Business and Professions Code, section 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security account number. Your social security account number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code, or for verification of license or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security account number, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

**DO NOT WRITE BELOW THIS LINE**

Livescan <input type="checkbox"/> Photo <input type="checkbox"/> Qualify Code _____ FP Clearance <input type="checkbox"/> Enf <input type="checkbox"/>	Registration No. _____ Date Issued _____	Application fee no. _____ Amount _____ Date Cashiered _____
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<b>Name of Applicant:</b> _____	<b>Social Security No:</b> _____
<b>AFFIDAVIT OF COMPLETED COURSEWORK OR GRADUATION</b> <b>This portion must be completed by the university, college, school or course provider</b>	
This is to certify that _____ attended <div style="text-align: center; font-size: small;">Name of Applicant</div> _____ <div style="text-align: center; font-size: small;">Name of College, University or School</div>	
From: _____ To: _____ and has <input type="checkbox"/> Completed all requirements for graduation; or <input type="checkbox"/> Completed 240 hours of instruction as required by section 1793.6 (c) of the California Code of Regulations	
The degree of _____ was conferred on her/him on _____	
Signed _____	Title _____ Date _____
Address: _____	
<div style="display: flex; justify-content: space-between;"> <span><b>Affix Seal Here</b></span> <div style="border-bottom: 1px solid black; width: 150px;"></div> </div> <div style="border-bottom: 1px solid black; width: 150px; margin-top: 5px;"></div>	

**You must provide a written explanation for all affirmative answers indicated below. Failure to do so may result in this application being deemed incomplete and being withdrawn.**

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 without exposing others to significant health or safety risks? <b>If "yes," attach a statement of explanation. If "no," proceed to #2.</b>  Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program?    Yes <input type="checkbox"/> No <input type="checkbox"/> <b>If "yes," attach a statement of explanation.</b>  If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted registration should be issued, whether conditions should be imposed, or whether you are not eligible for registration.	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Do you currently engage, or have you been engaged in the past two years, in the illegal use of controlled substances?  If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?    Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Attach a statement of explanation.</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Has disciplinary action ever been taken against your pharmacist license, intern permit or technician registration in this state or any other state? <b>If "yes," attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Continue on next page**

4. Have you ever had an application for a pharmacist license, intern permit or technician registration denied in this state or any other state? <b>If “yes,” attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you ever had a pharmacy permit, or any professional or vocational license or registration, denied or disciplined by a government authority in this state or any other state? <b>If “yes,” provide the name of company, type of permit, type of action, year of action and state.</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you ever been convicted of or pled no contest to a violation of any law of a foreign country, the United States or any state laws or local ordinances? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside under Penal Code section 1203.4. Traffic violations of \$500 or less need not be reported. <b>If “yes,” attach an explanation including the type of violation, the date, circumstances, location and the complete penalty received.</b> . In addition to this written explanation, please provide the Board of Pharmacy with <b>certified copies of all pertinent court documents or arrest reports relating to this conviction.</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, medical device retailer or any other entity licensed in this state or any other state? If yes, provide company name, type of permit, permit number and state where licensed.	Yes <input type="checkbox"/> No <input type="checkbox"/>

**APPLICANT AFFIDAVIT**

I, \_\_\_\_\_, hereby attest to the fact that I am the applicant whose signature appears below. I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I have read and understand the instructions attached to this application.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**MANDATORY REPORTER**

Under California law each person licensed by the Board of Pharmacy is a “mandated reporter” for both child and elder abuse or neglect purposes.

California Penal Code section 11166 and Welfare and Institutions Code section 15630 require that all mandated reporters make a report to an agency specified in Penal Code section 11165.9 and Welfare and Institutions Code section 15630(b)(1) [generally law enforcement, state, and/or county adult protective services agencies, etc... ] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child, elder and/or dependent adult whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or elder abuse or neglect. The mandated reporter must contact by telephone immediately or as soon as possible, to make a report to the appropriate agency(ies) or as soon as is practicably possible. The mandated reporter must prepare and send a written report thereof within two working days or 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Section 11166 and Section 15630 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars (\$1,000), or by both that imprisonment and fine.

For further details about these requirements, consult Penal Code sections 11164 and Welfare and Institutions Code section 15630, and subsequent sections.

**INSTRUCTIONS FOR COMPLETING A  
"REQUEST FOR LIVE SCAN SERVICE" FORM  
(California Residents)**

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

**NOTE TO APPLICANT and LIVE SCAN OPERATOR:** The applicant's name, date of birth and US Social Security Number must be entered in at the time of the Live Scan transmission in order for the results to be accepted by the Board of Pharmacy. If any of the applicant's name, date of birth or US Social Security Number are not entered at the time of Live Scan transmission, the applicant may have to have a new Live Scan transmission completed.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number
15. **Level of Service:** While the Live Scan forms contained in the board's application package are pre-plugged to indicate level of service at the DOJ and FBI level, please ensure at the time of Live Scan transmission that the Live Scan operator selects both the DOJ and FBI levels of service. If FBI is not selected at the time of original transmission, you may be required to have your Live Scan redone at another time and have to repay for the DOJ and FBI levels of services again. The board has been notified by the DOJ that effective 9/1/07, if the FBI level of service is not requested at the time of original transmission both DOJ and FBI levels of service will have to be redone. Any issue of cost for resubmission should be handled at the Live Scan Site level.

**Take the completed form** to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at <http://ag.ca.gov/fingerprints/publications/contact.htm> or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (DOJ processing fee of \$32, FBI processing fee of \$19, and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about \$5 to \$20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs. The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

**FINGERPRINTING AUTHORITY**

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ/FBI to conduct background checks for criminal convictions.

# REQUEST FOR LIVE SCAN SERVICE

## Applicant Submission

**ORI:** \_\_\_\_\_ Type of Application: (check one)  Employment  License, Certification, Permit  Volunteer  
Code assigned by DOJ  
Job Title or Type of License, Certification or Permit: \_\_\_\_\_

### Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information \_\_\_\_\_ Mail Code (five-digit code assigned by DOJ) \_\_\_\_\_  
Street No. \_\_\_\_\_ Street or PO Box \_\_\_\_\_ Contact Name (Mandatory for all school submissions) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ ( ) \_\_\_\_\_  
Contact Telephone No. \_\_\_\_\_

Name of Applicant: \_\_\_\_\_  
(Please print) Last First Middle

AKA's: \_\_\_\_\_ CDL No. \_\_\_\_\_  
Last First

DOB: \_\_\_\_\_ SEX:  Male  Female Misc. No. **BIL** - \_\_\_\_\_  
Agency Billing Number (if applicable)

HT: \_\_\_\_\_ WT: \_\_\_\_\_ Misc. No. \_\_\_\_\_

EYE Color: \_\_\_\_\_ HAIR Color: \_\_\_\_\_ Home Address: \_\_\_\_\_

POB: \_\_\_\_\_ Street or PO Box \_\_\_\_\_

SOC: \_\_\_\_\_ City, State and Zip Code \_\_\_\_\_

Your Number: \_\_\_\_\_  
OCA No. (Agency Identifying No.)

Level of Service DOJ  FBI

If resubmission, list Original ATI No. \_\_\_\_\_

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name \_\_\_\_\_

Street No. \_\_\_\_\_ Street or PO Box \_\_\_\_\_ Mail Code (five digit code assigned by DOJ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ ( ) \_\_\_\_\_  
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: \_\_\_\_\_ Date \_\_\_\_\_  
Name of Operator

Transmitting Agency \_\_\_\_\_ ATI No. \_\_\_\_\_ Amount Collected/Billed \_\_\_\_\_

# REQUEST FOR LIVE SCAN SERVICE

## Applicant Submission

**ORI:** \_\_\_\_\_ Type of Application: (check one)  Employment  License, Certification, Permit  Volunteer  
Code assigned by DOJ  
Job Title or Type of License, Certification or Permit: \_\_\_\_\_

### Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information \_\_\_\_\_ Mail Code (five-digit code assigned by DOJ) \_\_\_\_\_  
Street No. \_\_\_\_\_ Street or PO Box \_\_\_\_\_ Contact Name (Mandatory for all school submissions) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ ( ) \_\_\_\_\_  
Contact Telephone No. \_\_\_\_\_

Name of Applicant: \_\_\_\_\_  
(Please print) Last First Middle

AKA's: \_\_\_\_\_ CDL No. \_\_\_\_\_  
Last First

DOB: \_\_\_\_\_ SEX:  Male  Female Misc. No. **BIL** - \_\_\_\_\_  
Agency Billing Number (if applicable)

HT: \_\_\_\_\_ WT: \_\_\_\_\_ Misc. No. \_\_\_\_\_

EYE Color: \_\_\_\_\_ HAIR Color: \_\_\_\_\_ Home Address: \_\_\_\_\_

POB: \_\_\_\_\_ Street or PO Box \_\_\_\_\_

SOC: \_\_\_\_\_ City, State and Zip Code \_\_\_\_\_

Your Number: \_\_\_\_\_  
OCA No. (Agency Identifying No.)

Level of Service DOJ  FBI

If resubmission, list Original ATI No. \_\_\_\_\_

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name \_\_\_\_\_

Street No. \_\_\_\_\_ Street or PO Box \_\_\_\_\_ Mail Code (five digit code assigned by DOJ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ ( ) \_\_\_\_\_  
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: \_\_\_\_\_ Date \_\_\_\_\_  
Name of Operator

Transmitting Agency \_\_\_\_\_ ATI No. \_\_\_\_\_ Amount Collected/Billed \_\_\_\_\_



# REQUEST FOR LIVE SCAN SERVICE

## Applicant Submission

**ORI:** \_\_\_\_\_ Type of Application: (check one)  Employment  License, Certification, Permit  Volunteer  
Code assigned by DOJ  
Job Title or Type of License, Certification or Permit: \_\_\_\_\_

### Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information \_\_\_\_\_ Mail Code (five-digit code assigned by DOJ) \_\_\_\_\_  
Street No. \_\_\_\_\_ Street or PO Box \_\_\_\_\_ Contact Name (Mandatory for all school submissions) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ ( ) \_\_\_\_\_  
Contact Telephone No. \_\_\_\_\_

Name of Applicant: \_\_\_\_\_  
(Please print) Last First Middle

AKA's: \_\_\_\_\_ CDL No. \_\_\_\_\_  
Last First

DOB: \_\_\_\_\_ SEX:  Male  Female Misc. No. **BIL** - \_\_\_\_\_  
Agency Billing Number (if applicable)

HT: \_\_\_\_\_ WT: \_\_\_\_\_ Misc. No. \_\_\_\_\_

EYE Color: \_\_\_\_\_ HAIR Color: \_\_\_\_\_ Home Address: \_\_\_\_\_

POB: \_\_\_\_\_ Street or PO Box \_\_\_\_\_

SOC: \_\_\_\_\_ City, State and Zip Code \_\_\_\_\_

Your Number: \_\_\_\_\_  
OCA No. (Agency Identifying No.)

Level of Service DOJ  FBI

If resubmission, list Original ATI No. \_\_\_\_\_

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name \_\_\_\_\_

Street No. \_\_\_\_\_ Street or PO Box \_\_\_\_\_ Mail Code (five digit code assigned by DOJ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ ( ) \_\_\_\_\_  
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: \_\_\_\_\_ Date \_\_\_\_\_  
Name of Operator

Transmitting Agency \_\_\_\_\_ ATI No. \_\_\_\_\_ Amount Collected/Billed \_\_\_\_\_