



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
**DEPARTMENT OF STATE**  
DIVISION OF PROFESSIONAL REGULATION  
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: DPR.DELAWARE.GOV

## APPLICATION FOR REGISTRATION OF INTERNSHIP – FOREIGN SCHOOL

File this application form if you:

- Graduated from a Pharmacy School or College outside the U.S.
- Passed an equivalence exam recognized by the Board. The Foreign Pharmacy Graduate Examination Committee (FPGEC) certification meets this requirement.
- Wish to work as a Pharmacist Intern in a Delaware Pharmacy to attain required pre-licensure hours of experience.

If you are a graduate of School or College of Pharmacy in the U.S., this form does not apply to you. File the [Application for Registration of Internship-U.S. School](#) form instead.

If you have graduated and wish to take the NAPLEX, you must also submit an [Application for Pharmacist Licensure by Examination or Score Transfer](#) form.

### IDENTIFYING AND CONTACT INFORMATION

1. Name \_\_\_\_\_  
Last First Middle
2. Other Names Used: \_\_\_\_\_  
(Include maiden, prior married, alternate spellings)
3. Mailing Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip
4. Phone: \_\_\_\_\_ Email: \_\_\_\_\_
5. Date of Birth (mm/dd/yyyy): \_\_\_\_\_
6. Have you been issued a U.S. Social Security Number? Yes  No 
  - If yes, enter your SSN: \_\_\_\_\_
  - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

### EDUCATION INFORMATION

7. Name of School or College of Pharmacy: \_\_\_\_\_
8. Enter the date you graduated: \_\_\_\_\_
9. Enter the date of your FPGEC certification: \_\_\_\_\_

**Enclose a copy of your FPGEC certification.**

### PRECEPTOR INFORMATION

10. Full Name of Preceptor: \_\_\_\_\_ License #: \_\_\_\_\_

11. Preceptor Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City State Zip

Arrange for your Preceptor to submit the *Affidavit of Preceptor* form. When you complete your internship with this Preceptor, arrange for the Preceptor to submit the *Affidavit of Intern Experience* form. If your preceptor changes, you must submit a new *Affidavit of Preceptor* form within 10 calendar days of the change.

**DISCLOSURES**

- 12. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor, or any other criminal offense, including any offense for which you received a pardon, in any jurisdiction? Yes  No  **If yes, you must arrange for the Board office to receive a criminal background check. See *Instructions for Requesting a Criminal Background Check* at [dpr.delaware.gov](http://dpr.delaware.gov).**
- 13. Have you ever been the recipient of an administrative penalty regarding your practice of pharmacy, including but not limited to fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations, or been a party to a consent agreement containing conditions placed by a Board on your professional conduct and practice, including any voluntary surrender of a license? Yes  No  **If yes, provide documentation of the regulatory Board action.**
- 14. Do you have any impairment related to drugs, or alcohol, or mental competence that would limit your ability to act as a pharmacist in a manner consistent with the safety of the public? Yes  No

Enclose non-refundable processing fee. See [Fee Schedule](http://dpr.delaware.gov) at [dpr.delaware.gov](http://dpr.delaware.gov).

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items **no later than 4:30 PM ten full working days before the Board's meeting date:**

- Completed, signed and notarized application form
- Fee payment
- All required supporting documentation.

Applications that are not complete within six months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your registration.

**AFFIDAVIT**

I do hereby make application to the Board of Pharmacy for license or registration under the provisions of an Act to regulate the practice of Pharmacy in the State of Delaware and solemnly swear and affirm that the answers to the questions set forth in this application are true and correct.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 2\_\_\_\_\_

Witness my hand and seal hereunto attached.

SEAL

Notary Signature \_\_\_\_\_  
My Commission expires: \_\_\_\_\_

**APPLICATIONS THAT ARE UNSIGNED, INCOMPLETE, NOT NOTARIZED OR NOT ACCOMPANIED BY THE REQUIRED PROCESSING FEE WILL BE REJECTED.**



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**AFFIDAVIT OF PRECEPTOR**

To be completed by the Applicant and submitted to the preceptor:

Name of Applicant: \_\_\_\_\_

To be completed by the applicant's preceptor then sent **directly** to the Board.

I hereby certify that I, \_\_\_\_\_, License # \_\_\_\_\_, accept the responsibility of a preceptor for the applicant named above. I agree to provide the applicant with the experience outlined in the Board's Practical Experience Program. If I terminate my preceptorship agreement with the applicant, I will notify the Board in writing within 10 calendar days. I also hereby certify that I am a licensed pharmacist and have been practicing for at least two years.

PRECEPTOR SIGNATURE : \_\_\_\_\_ Date: \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 2\_\_\_\_\_  
Witness my hand and seal hereunto attached.

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

My Commission expires: \_\_\_\_\_

SEAL

**Send this form *directly* to the Board of Pharmacy office at the address above.**