

MINNESOTA BOARD OF PHARMACY

APPLICATION FOR REINSTATEMENT OF PHARMACIST LICENSURE

1. Name: _____ License #: _____
2. Former Name: _____
3. Designated Address: _____

4. Designated Phone Number: _____
5. Designated Fax Number (optional): _____
6. Designated E-Mail Address (optional): _____
7. If you are licensed as a pharmacist in any other states please list them below and have them send us a letter verifying that you are active and in good standing.

8. Have you worked in the field of pharmacy during the last two years? Yes No

If yes, please have your most recent pharmacy employer send us a letter confirming the dates of your employment.

9. On a separate sheet of paper please list your work history since you dropped your license in Minnesota.
10. Please list any other licenses/registrations that you have obtained from any other licensing agency.

Profession

Licensing Agency

11. Have you ever been charged with or convicted of a felony or misdemeanor involving controlled substance abuse, habitual indulgence of intoxicating liquor, or of moral turpitude or have you been found by any licensing agency to have engaged in unprofessional conduct? Yes No

If the answer is "Yes", please attach documentation that explains the violation. If no, you are certifying, by signing below, that no such charges or convictions have occurred.

I hereby certify that the above information and attached information is true and accurate.

SIGNATURE

DATE