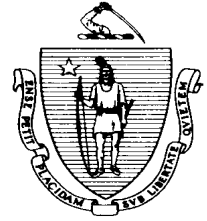


**Massachusetts Board of  
Registration in Pharmacy**

**Pharmacy Technician  
Registration Application**



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The Massachusetts Board of Registration in Pharmacy (Board) has contracted with Professional Credential Services (PCS) to process registration applications from pharmacy technicians. Applicants must submit all information directly to PCS. Applicants must meet one of the following registration requirements to be licensed as a Pharmacy Technician in Massachusetts:

**Registration Requirements for Non-Certified Applicants (247 CMR 8.02)**

- 1) Be at least 18 years of age.
- 2) Be of good moral character and not been convicted of a drug-related felony.
- 3) Have a high school diploma or equivalent or currently enrolled in a program that awards such degree or certificate.
- 4) Have completed a Board-approved training program or a minimum of 500 hours of employment as a pharmacy technician trainee.
- 5) Passed a Board-approved pharmacy technician assessment examination administered by the employer or the employer's agency

**Registration Requirements for Certified Applicants (247 CMR 8.04)**

- 1) Be at least 18 years of age
- 2) Be of good moral character and not been convicted of a drug-related felony
- 3) Have a high school diploma or equivalent or currently enrolled in a program that awards such a degree or certificate
- 4) Currently certified by the Exam for the Certification of Pharmacy Technician (EXCPT) or the Pharmacy Technician Certification Board (PTCB).

**Application Instructions**

Applicants must complete the attached application and submit it to PCS with required fees. Applications should be typewritten or legibly printed in blue or black ink. An applicant must have a Social Security Number or an Affidavit in Support of Registration to be registered with the Board. The applicant must sign the completed application in the presence of a notary public and attach a 2" x 2" photo of the applicant. Non-Certified Applicants: A Pharmacy employer must verify employment history by completing the Employer Verification of Experience and Examination form enclosed. Certified Applicants must provide a copy of their current PTCB/EXCPT Certification Registration.

Applicants registered as a Pharmacy Technician in another U.S. jurisdiction must attach a letter of official verification from the Board of original registration. A copy of the certificate will not be accepted.

Once all documentation is received by PCS, the application will be reviewed; if approved, PCS will notify the applicant and assign an official Massachusetts registration number within ten (10) business days from the date that PCS received the application. The Board will issue the official registration card within four to six weeks of registration number assignment.

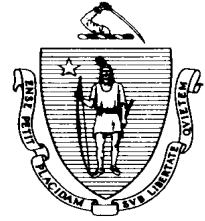
**Application Fee**

\$150.00—Forms of Payment include: Visa, MasterCard, Discover or Money Order (made payable to PCS); see attached Payment Form. *Fees submitted cannot be refunded or transferred.*

**Contact Information**

Applicants may contact PCS with questions regarding registration, or to inquire about application status by calling toll-free (877) 887-9727 (8:00am-4:30pm CST) or email [techlicense@pcshq.com](mailto:techlicense@pcshq.com).

**Application Materials must be submitted to:**  
Professional Credential Services  
Attn: Pharmacy Coordinator  
P.O. Box 198788, Nashville, TN 37219-8689



All Pharmacy Technicians working in the Commonwealth of Massachusetts must complete this form and be registered with the Board of Registration in Pharmacy prior to working in a Pharmacy as a Pharmacy Technician.

SOCIAL SECURITY NUMBER (SSN) |\_|\_|\_|-|\_|\_|-|\_|\_|\_|\_|

**A. Biographical Information.**

Provide all information as requested. Applications are not considered complete until all requested information is provided.

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Suffix/Other/Maiden \_\_\_\_\_

MOTHER'S MAIDEN NAME \_\_\_\_\_  FEMALE  MALE

DATE OF BIRTH |\_|\_|\_|\_|\_|\_| CITY/STATE/COUNTRY OF BIRTH \_\_\_\_\_

HEIGHT \_\_\_\_\_ (FT) \_\_\_\_\_ (IN) WEIGHT \_\_\_\_\_ (LBS) EYE COLOR \_\_\_\_\_

**Home Address**

Street Address or P.O. Box \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_ Email Address \_\_\_\_\_

**B. Academic and Professional**

**Credentials.** Applicants should review registration requirements at 247 CMR 8.02 or 247 CMR 8.04 on-line at: [www.mass.gov/dph/boards.ph](http://www.mass.gov/dph/boards.ph)

Name of High School \_\_\_\_\_ City/State/Country of High School \_\_\_\_\_

Did you earn: (*indicate one*) Diploma  Graduation Date: \_\_\_\_\_  
 mm/dd/yy

GED  Graduation Date: \_\_\_\_\_  
 mm/dd/yy

Please complete one of the following categories:

**1) Certified Applicants**

Certification program for pharmacy technicians  
 Please indicate one:  EXCPT  PTCB

Certificate Number \_\_\_\_\_

Date of Examination: \_\_\_\_\_  
 Month/Day/Year

Certification Status: Current   
 Expired

Certified applicants MUST provide a copy of their current PTCB/EXCPT Certification Registration.

**B. Academic and Professional Credentials.** Applicants should review registration requirements at 247 CMR 8.02 or 247 CMR 8.04 on-line at: [www.mass.gov/dph/boards.ph/](http://www.mass.gov/dph/boards.ph/).

**2) Non-Certified Applicants**

Have you passed a Board-approved Pharmacy Technician Assessment exam? Yes  No

Date of Examination: \_\_\_\_\_ Score: \_\_\_\_\_ (min. passing score of 75% required)  
Month/Day/Year

Location of Examination: \_\_\_\_\_

Administered by (employer): \_\_\_\_\_

Please indicate which of the following requirements you have completed:

- A minimum of 500 hours of employment as a pharmacy technician trainee
- A Board-approved pharmacy technician training program

Verification of experience must be provided by employer on the attached Employer Verification Form.

Have you ever been registered as a Pharmacy Technician in another state or U.S. jurisdiction?

Yes  No

*If yes, please complete the following:*

State	License Number	Date Licensed	Current	Lapsed	Revoked or Suspended	Probation

If you are registered as a Pharmacy Technician in another state, you must obtain a letter of verification of licensure from each state, either current or expired. It must be in letterform and on letterhead of the board where registered. A copy of your registration card is not acceptable.

**D. Questions.**

Answer each of the questions listed. If you answered yes to any, please attach a **personal statement** of explanation. All questions must be answered. A certified copy of any conviction (No. 5) must **also be included with your personal statement.**

1. Has any disciplinary action been taken against you by a licensing or certification board located in the United States or any country or foreign jurisdiction?  Yes  No
2. Are you the subject of pending disciplinary action by any licensing or certification board located in the United States or any country or foreign jurisdiction?  Yes  No
3. Have you voluntarily surrendered or resigned a professional license to a licensing or certification board in the United States or any country or foreign jurisdiction?  Yes  No
4. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?  Yes  No
5. Have you been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any investigation or any court proceeding in relation to any felony or misdemeanor charge? If YES, please attach a typewritten 8 1/2" by 11" sheet(s) of paper which provides dates and details describing the circumstances related to the matter(s); provide certified copies of court documents of any convictions (defined as any plea that is accepted by a court); and complete a Criminal Offender Record Information Request (CORI) Form (available at [peshq.com](http://peshq.com)).  Yes  No

(Note: Conviction of a crime does not necessarily bar registration; however, failure to disclose may result in denial of application or other disciplinary action by the Board.)

**E. Affidavit.**

Application must be signed in the presence of a notary public. Application will not be processed unless signed by the applicant and notarized.

**By my signature below, I certify under the pains and penalties of perjury, that:**

1. I am the applicant named in this application and pictured in the attached photograph.
2. The information that I have provided pursuant to this application is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Board of Registration in Pharmacy to deny this application and/or revoke the right to function as a Pharmacy Technician, in accordance with Massachusetts law.
3. I understand that the Massachusetts Board of Registration in Pharmacy has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an applicant for initial licensure and/or registration by examination or by reciprocity, I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me.
4. I agree that in the event my examination papers are lost, or if the examination is not held for any reason, any claim that I may have will be limited to the examination fee paid by me.
5. I understand that this application is void if requirements are not met within one year from the date of receipt. I also understand that the fees are non-refundable and non-transferrable.
6. I am responsible for reading, understanding, and abiding by the rules and regulations of the Board of Registration in Pharmacy; statutes pertaining to the practice of pharmacy (M.G.L. c.112, ss. 24-42 and c. 94C); and 247CMR (Commonwealth of Massachusetts Regulations).
7. Pursuant to M.G.L. c. 119, s. 51A and M.G.L. c. 112, s. 1A, I understand my obligation to report the abuse or neglect of children.
8. Pursuant to M.G.L. c. 62C, s. 49A, to the best of knowledge and belief, I have filed all Massachusetts state income tax returns and paid all taxes required by law.

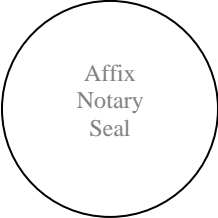
Attach  
2 x 2 Photo of  
Candidate

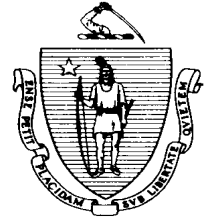
\_\_\_\_\_  
Applicant Signature *(signed in the presence of a Notary Public)* \_\_\_\_\_  
Date

Print Name of Notary Public \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

My commission expires on: \_\_\_\_\_  
Month/Day/Year





**Payment Form**

**Pharmacy Technician Application Fee - \$150**

Please check form of payment below:

- Money Order

Please make it payable to "PCS" for the total amount of the application fee. Do Not staple your payment to this form.

**Or**

- Credit Card

Authorized payment amount: \$ \_\_\_\_\_ Please check one:  Visa  MasterCard  Discover

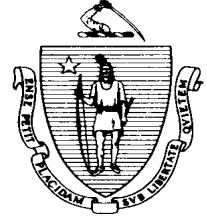
Card Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Exp: \_\_\_\_ / \_\_\_\_

Print name as it appears on account: \_\_\_\_\_

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

**Return this payment form with Application/Scheduling Form.**

**NOTE:** this document will be shredded after it has been processed.



## Employer Verification of Experience and Examination

**This form is to be completed by the Pharmacist Employer for Non-Certified Applicants.**

**A. Applicant Information.**  
 Provide information of Pharmacy Technician who is to be registered.

*Please type or print using blue or black ink only.*

First Name	Middle Name	Last Name	Other/Maiden
Date of Birth		Social Security Number or Affidavit in Support of Registration	

**B. Pharmacist Information.**  
This section is to be completed by the Pharmacist Employer.

Applicant Does Not Complete This Section.

Supervising Pharmacist must complete this section on behalf of applicant prior to submitting form to PCS.

Pharmacist's Name	State License No.	License Expiration Date
Pharmacy Name		
Pharmacy Location: Street Address		
City	State	ZIP Code
Email Address	Telephone Number	

- 1) Is the applicant named above currently working under your supervision?  Yes  No
  
- 2) Training / Experience  Yes  No
  - A.) Successfully completed hours of supervised experience as a pharmacy technician trainee  Yes  No  
 List the number of hours \_\_\_\_\_
  - B.) Successfully completed a Board-approved training program  Yes  No  
 Identify the Board-approved training: \_\_\_\_\_
  
- 3.) Did the applicant pass a Board-approved pharmacy technician assessment examination?  Yes  No  
 Date of examination: \_\_\_\_\_ Score: \_\_\_\_\_ (min. passing score of 75% required)  
 Administered by (employers name): \_\_\_\_\_

By my signature below, I hereby certify, under the penalties of perjury, that the information above is true and accurate.

Signature of Pharmacist	Date
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