



VIRGIN ISLANDS BOARD OF PHARMACY

***Department of Health
P.O. Box 222995
Christiansted, VI 00822-2995
Tel: 340-718-1311
Email: BoardofPharmacy@doh.vi.gov***

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,

Amy Durand, 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.

e-Profile ID: _____

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: _____

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(s).

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.
13. Submit a current (dated within 6 months of VI application) National Practitioner Data Bank self-query.
 - A. Visit <https://www.npdb.hrsa.gov/ext/selfquery/sqhome.jsp> and begin the process for the self-query. Follow all instructions given.
 - B. After your self-query has been processed by the NPDB, they will send the self-query report directly to you.
 - C. You must first open this report to make sure that the results were not rejected, and all information submitted is correct.
 - D. Send all parts of the self-query report directly to our office with your application.
 - E. For NPDB questions or assistance, call **800-767-6732** or email help@npdb.hrsa.gov.

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:
VI Board of Pharmacy, P.O. Box 222995, Christiansted, VI 00822-2995



VIRGIN ISLANDS BOARD OF PHARMACY

P.O. 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, P.O. 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:

Signed: _____

Title: _____

State Board: _____

Date: _____

BOARD SEAL



VIRGIN ISLANDS BOARD OF PHARMACY

Department of Health
P.O. 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

My Commission Expires

SEAL



**VIRGIN ISLANDS BOARD OF PHARMACY
DEPARTMENT OF HEALTH
P.O. 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