Pharmacist Renewal

____Renewal application

____2x2 photo

____30 CPE credit hours

____Nonrefundable fee of $200 payable to “CNMI TREASURER”

-Schedule of Fees

Application fee	$100
Initial license fee	$200
Renewal fee	$200
Delinquent fee (double the fee for renewal)	$200
Replacement/Duplication of license	$75
Replacement/Duplication of wallet size card	$25
Letter of Good Standing/Verification fee	$25

Commonwealth of the Northern Mariana Islands
HEALTH CARE PROFESSIONS LICENSING BOARD
P.O. Box 502078, Bldg., 1242 Pohnpei Court
Capitol Hill, Saipan, MP 96950
Tel No: (670) 664-4808/4809 Fax: (670) 664-4814
Email: info@cnmilicensing.gov.mp
Website: www.cnmilicensing.gov.mp

Attach a recent 2x2 ID photo here taken within 6 months of the application.

RENEWAL APPLICATION TO PRACTICE

Pharmacist

HCPLB STAFF USE ONLY

Date Received:

APPLICATION INFORMATION – Please Type or Print

1. Last:	First:	Middle:	**2.** Social Security No:
3. Birthdate: (Mo/Day/Yr.)	**4.** Email Address:	**5.** Citizenship: ____U.S. ____Other-Specify:	
6. Mailing Address:		**7.** Residence Address:	
8. Phone No: (W): (H):		**9.** NPI # (if available):	

10. LICENSES – (*List of all jurisdictions where you are licensed.)*

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

11. Name/Address of Intended Employment within the CNMI:

If you answer "yes" for any of items 12-27 you must attach a detailed explanation on a separate sheet, which includes state or country where action is pending or took place, relevant dates, action taken and reasons for such action. (Include Findings of Fact, Conclusion of Law, Final Order and whether you have been reinstated. If reinstated, date and conditions of license.

12. Since the date of your last application for a license in the Commonwealth or within the past two years, have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts against you for your profession by any licensing board, other agency, or healthcare facility?	Yes ☐	No ☐
13. Since the date of your last application for a license in the Commonwealth or within the past two years, has a claim or an action ever been filed against you for your profession which resulted in a settlement, judgment, or arbitration award of $25.000 or more?	Yes ☐	No ☐
14. Since the date of your last application for a license in the Commonwealth or within the past two years, has any licensing board, other agency, or disciplinary authority refused to issue you a license, renew your license, suspended, revoked, accepted surrender of your license, placed on probation or conditioned your license, held by you now or previously, or ever fined or otherwise disciplined you?	Yes ☐	No ☐
15. Since the date of your last application for a license in the Commonwealth or within the past two years, is there any ongoing or pending investigation against you?	Yes ☐	No ☐

16. Since the date of your last application for a license in the Commonwealth or within the past two years, is there any disciplinary action pending against you?	Yes ☐	No ☐
17. Since the date of your last application for a license in the Commonwealth or within the past two years, has any healthcare facility or training program restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures?	Yes ☐	No ☐
18. Since the date of your last application for a license in the Commonwealth or within the past two years, has your ability to practice your profession in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?	Yes ☐	No ☐
19. Since the date of your last application for a license in the Commonwealth or within the past two years, have you used or are you currently using any chemical substances(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice your profession in a safe and competent manner?	Yes ☐	No ☐
20. Since the date of your last application for a license in the Commonwealth or within the past two years, have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	Yes ☐	No ☐
21. Since the date of your last application for a license in the Commonwealth or within the past two years, have you been treated for or had a recurrence or a diagnosed addictive disorder?	Yes ☐	No ☐
22. Since the date of your last application for a license in the Commonwealth or within the past two years, have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice your profession safely?	Yes ☐	No ☐
23. Since the date of your last application for a license in the Commonwealth or within the past two years, do you have any other condition in which in any way impairs or limits your ability to practice your profession safely?	Yes ☐	No ☐
24. Since the date of your last application for a license in the Commonwealth or within the past two years, have you ever been found guilty, pleaded guilty, no contest, or nolo contendere to a crime involving moral turpitude or crime related to your profession, or felony in any court?	Yes ☐	No ☐
25. Since the date of your last application for a license in the Commonwealth or within the past two years, is there any criminal action pending against you in any court?	Yes ☐	No ☐
26. Since the date of your last application for a license in the Commonwealth or within the past two years, are you required to register as a Sex Offender?	Yes ☐	No ☐
27. Since the date of your last application for a license in the Commonwealth or within the past two years, have you been engaged in telemental health services from outside the CNMI?	Yes ☐	No ☐

28. **DECLARATION:**

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content hereof. I declare that all the information contained herein, and evidence or other credentials submitted herewith are true and correct. I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification on misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license to practice a health profession in the Commonwealth of the Northern Mariana Islands. I further certify that I have read and will abide by P.L. 15-105 and the HCPLB Regulations regulation of my health profession.

_____ _____

Signature of Applicant Date

Please complete the application form and attach the renewal fee (money order or cashier's check make payable to "CNMI Treasurer"). Do not send Cash.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ (print name), do hereby authorize a disclosure of records concerning myself to the Health Care Professions Licensing Board (HCPLB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the HCPLB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the HCPLB relating to substance abuse or dependence and/or mental health.

I further agree that the HCPLB may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, and fellowship) records, including records or any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the HCPLB deems reasonably necessary for the purposes set forth in this release.

Release of Liability:
I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the HCPLB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the HCPLB, the Commonwealth of the Northern Mariana Islands, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

I have read and fully understand the contents of this "Authorization to Release Information".

_____ _____
Signature of Applicant Date