



OKLAHOMA STATE BOARD OF PHARMACY

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Phone: (405) 521-3815 / Fax: (405) 900-8365
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E-mail: pharmacy@pharmacy.ok.gov

FOR OSBP USE ONLY		
RECEIPT:		AFFIDAVIT__
DATE:		

2023-2024 NOTICE OF RENEWAL OF PHARMACIST LICENSE

License No. _____

Please PRINT clearly

Fee doubles 15 days after expiration

EXPIRES: _____

Name _____

FEES: **(ONLINE ONLY)** [check all that apply]

Address _____

<https://pay.apps.ok.gov/OSBP/payments/>

City, State, Zip _____

Active/Inactive	<input type="checkbox"/>	-	\$100
Sr. Inactive	<input type="checkbox"/>	-	\$20
Preceptor	<input type="checkbox"/>	-	\$10

Section I. Renewal (expires last day of birth month)

✓ Check all that apply:

- I request **Active** renewal of for a fee of **\$100.00**. I certify that I have obtained **fifteen (15) clock hours** of continuing education credits through satisfactory completion of an accredited program **during the previous calendar year (i.e. Jan-Dec 2021)** as stated in Section VI.
- I request **Inactive** renewal for a fee of **\$100.00**. I understand that I may not practice pharmacy in Oklahoma while Inactive. I am NOT required to complete CE.
- I am **retired and age 65 or over**. I request **Senior Inactive** renewal for a fee of **\$20.00**. I understand that I may not practice pharmacy in Oklahoma while Senior Inactive. I am NOT required to complete CE.
- I am currently a licensed **PRECEPTOR**. I request renewal of my preceptor permit for a fee of **\$10.00**. I understand that my preceptor permit expires annually at the same time as my pharmacist license.

PLEASE ALLOW 2-3 WEEKS FROM DATE OF RECEIPT FOR PROCESSING.

Section II. Contact Information

Home Phone: _____ Cell Phone: _____ Home e-mail: _____

Section III. Current Primary Employment (if necessary, attach separate page for additional employment)

Employer Name: _____

Employer Address: _____

Date of employment (mo/yr) _____ Employer's OK Phcy Lic # _____ Full-Time Part-Time

Work Phone: _____ Work Fax: _____ Work e-mail: _____

Section IV. Practice (practice information to be answered for your primary employment)

- CHAIN INDEPENDENT HOSPITAL LONG TERM CARE RELIEF
 EDUCATION GOVERNMENT OTHER _____

Are you currently practicing pharmacy in Oklahoma? ___ YES ___ NO

Section V. Charges and Convictions (✓one)

I ___ HAVE ___ HAVE NOT been the subject of a disciplinary action or other action by any other licensure Board in this state or any other state, or been arrested, charged, indicted, or convicted, or received a deferred sentence for any misdemeanor or felony offense since my last renewal or within the last 24 months.

If you HAVE, you must complete an 'Addendum to Application with Charges & Convictions' form and attach to this application. The addendum may be found at: https://ok.gov/pharmacy/Licensees_&_Applicants/Forms_&_Applications/Pharmacists/index.html

Section VI. Continuing Education (Active Renewal Only)

- (1) List below 15 clock hours of CE obtained in the **previous calendar year (Jan 1 – Dec 31, 2021)**. CE verification forms of these programs are to be maintained by the pharmacist signing below for a period of two years from the date this renewal is submitted.
- (2) **New graduates are NOT exempt from reporting CE and must complete the following:**
 - (a) Name of Program = the name of the pharmacy school (e.g. OUCOP, SWOSU COP) attended during the previous calendar year (2021)
 - (b) Completion Date = the last date (mo/year) enrolled in pharmacy school during previous calendar year (e.g. 05/2021, 12/2021)
 - (c) # Hours = 15.
- (3) **If you completed a program that was Board approved but not ACPE approved**, please list the OSBP CE Approval # in the ACPE column.
- (4) **If you attended a live program**, the completion date is the date that you attended the program.
- (5) **If you participated in a correspondence/online course**, these courses are not complete until a certificate of completion has been issued. The following are accepted for the completion date:
 - Activity / Program Date (CPE Monitor)
 - Date issued / earned
 - Date of authorized signature
 - Date exam processed

(CE Certificates and/or CPE Monitor transcript may be attached)

Name of Program	ACPE Number	Completion Date (mo/yr)	Live? √	# Hours	
<i>(continue on separate sheet if necessary)</i>				TOTAL:	

Section VII. Swear and Affirm

I SUBSCRIBE TO THE RULES OF PROFESSIONAL CONDUCT.

I swear and affirm under penalty of perjury pursuant to Title 21 O.S. 491 and/or discipline by the Board of Pharmacy under the pharmacy laws and rules of the State of Oklahoma that all information I have supplied herein is true and complete.

Signature _____ Date _____