



South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Pharmacy
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11927 • Columbia • SC 29211-1927
Phone: 803-896-4700 • Contact: pharmacy@llr.sc.gov • Fax: 803-896-4596
llr.sc.gov/bop

LICENSURE BY LICENSE EXAMINATION REQUIREMENTS AND INSTRUCTIONS

In order to become licensed as a pharmacist in South Carolina, the law requires that an applicant present to the Board of Pharmacy satisfactory evidence that the applicant has:

1. Completed 1,500 hours of practical experience in pharmacy under the supervision of a licensed pharmacist, which shall be approved by the South Carolina Board of Pharmacy.
2. Received a Bachelor of Science in Pharmacy or a Doctor of Pharmacy degree from an accredited school, college or department of pharmacy as determined by the Board.
3. Passed the examinations required and approved by the South Carolina Board of Pharmacy and paid all required fees.

PRACTICAL EXPERIENCE REQUIREMENTS

The required practical pharmacy experience must have been gained in accordance with South Carolina internship requirements. Completion of the practical experience is not required in order to take the licensure exam, but the practical experience must be completed prior to licensure. Practical experience worked in South Carolina will not be credited unless an internship certificate was issued prior to the experience.

OUT OF STATE INTERN HOURS

Please remit documentation of 500 intern hours. These hours must have been worked under a licensed pharmacist. Please contact the Board of Pharmacy from the state in which you acquired intern hours and request that verification (**with the state SEAL**) be forwarded to this office.

If intern hours were not reported to a State Board of Pharmacy:

The Pharmacist-in-Charge of the pharmacy in which you worked must submit a letter on company letterhead verifying the total number of intern hours obtained and provide the following information:

- Verifying Pharmacist's name and license number
- Name of pharmacy, address and permit/license number
- Submit a copy of current facility(s) permit/license
- Submit a copy of verifying pharmacist's current license

APPLICATION PROCEDURE FOR EXAMINATION

The process of applying for examination in South Carolina consists of three separate forms:

- South Carolina Board of Pharmacy Application for Examination
- North American Pharmacist Licensure Examination(NAPLEX)
- Multistate Pharmacy Jurisprudence Examination(MPJE)

Study material recommendations and links can be found online at:

- <https://llr.sc.gov/bop/laws.aspx>
- Your best resource would be the SCPhA website: <https://scrx.org/ce-events/ce-on-demand/mpje/>

1. **Download and read the entire NAPLEX/MPJE Registration Bulletin and follow instructions explicitly.**

The Registration Bulletin is on the web at <https://nabp.pharmacy/>

Once you have submitted this application to the SC Board of Pharmacy, you may apply for the NAPLEX and MPJE exams on the NABP website: <https://nabp.pharmacy/>

- There is a **\$575** fee for the NAPLEX
- There is a **\$250** fee for the MPJE

The examinations are administered by Pearson VUE daily Monday through Saturday, except holidays.

Pearson VUE will provide the Authorization to Test (ATT) and confirmation letters. The ATT provides all the scheduling information you require and the confirmation letter will include verification of the exam date and time as well as the address of the testing center.

NAPLEX and MPJE scores are received electronically from NABP approximately ten business days after the exam. You will be notified by email of your scores.

2. Complete the SC Board of Pharmacy Application for Examination.

Include with your application:

- Payment in the amount of \$100 (application fee) in the form of a check or money order made payable to: LLR – SC Board of Pharmacy
 - Application fee is non-refundable.
 - A returned check fee of up to \$30, or an amount specified by law, **may** be assessed on all returned funds.
- Copy of your valid Driver's License, State Issued ID, Passport or Military ID
- Copy of your Social Security card
- Copy of birth certificate
- Certification of Clinical Experience
- Photograph with Character Voucher Form
- Pharmacist Signature Affidavit

3. **Once you have passed the NAPLEX and MPJE** and completed the required practical experience, you will receive a Pharmacist's Initial Licensure Application. You must complete the Initial Licensure application form and pay the non-refundable \$98 initial licensure fee. Your license will be mailed to you within ten business days.

Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period; you must begin the application process from the beginning. This includes, but is not limited to, the application fee, license verifications, etc. All fees are non-refundable.

If you move during the licensure process, please advise the Board of Pharmacy in writing of your new address, indicating that you are a candidate for examination.



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PHARMACIST APPLICATION BY EXAMINATION

Include with your application:

- Check or money order (no cash) in the amount of \$100 made payable to LLR-Board of Pharmacy. Application fee is non-refundable. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.
• Copy of your valid Driver's License, State Issued ID, Passport or Military ID
• Copy of your Social Security card
• Certified copy of birth certificate
• Certification of Clinical Experience
• Photograph with Character Voucher Form

Table with 2 columns and 4 rows: License No., Check No., Issued, Amount paid. Header: For Board Use Only

APPLICANT INFORMATION

First Name: Middle: Last:

Since you were last licensed, have you legally changed your name? Yes No Prior Name:
If yes, please submit legal documentation supporting the change. (Marriage certificate, divorce decree, etc.)

Home Address: City: State: Zip:

Mailing Address: City: State: Zip:
(If different than above)

Phone No.: Cell No.:

Email: Social Security No.:

Place of Birth (City, State or Country):

Date of Birth: Race: Gender: Female Male
(For statistical purposes only) (For statistical purposes only)

Business Name: Phone:

Business Address:

EDUCATION

Pharmacy College must be an accredited school, college or department of pharmacy as determined by the Board.

Name of School	LOCATION (City and State or Country)	GRADUATION DATE	DEGREE
Pharmacy School			
Undergraduate College			

1. Did you complete the 500 Intern hours required for licensure in the State of South Carolina? Yes No
- a) If No, have the Board of Pharmacy in the state in which you have completed your 500 intern hours send verification of those hours to the SC Board of Pharmacy.

PRIOR EXAMINATION RECORD

If you have previously taken the Board examination for pharmacist licensure in this or any other state, you must disclose the location, date(s) and result(s).

State: _____ Date exam taken: _____ Results: Passed Failed

State: _____ Date exam taken: _____ Results: Passed Failed

PRIOR LICENSURE AS PHARMACIST

List any states in which you were previously licensed in. Attach an additional sheet, if needed.

State: _____ Date licensed: _____ License No.: _____ Status: _____
(active, lapsed, etc.)

State: _____ Date licensed: _____ License No.: _____ Status: _____
(active, lapsed, etc.)

If licensed in another state, list current and prior work information. Attach an additional sheet if needed.

Business Name: _____ Address: _____

Business Name: _____ Address: _____

PERSONAL HISTORY

A "Yes" answer requires a full written explanation to be attached as well as any other requested documentation.

- Are you currently being treated for any condition, be it physical, mental and/or emotional, that could impair your ability to serve as a pharmacist? If Yes, include documentation from your physician along with your written explanation. Yes No
- Have you ever been convicted of or pled guilty or nolo contendere to a felony of any kind or to a non-felony crime involving drugs or moral turpitude? If Yes, attach certified copies of any pertinent legal and/or court documents along with your written explanation. Yes No
- Are you currently under investigation or the subject of pending disciplinary action by any pharmacy licensing board, health care facility or other entity? Yes No

AFFIDAVIT

I _____ am the person described and identified, of good moral character, and the person named in all documents presented in support of this application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me here in are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such act shall constitute the cause for denial or revocation of my license to practice as a Pharmacist in South Carolina.

Signature of Applicant

Print Name of Applicant

Subscribed and sworn to before me this _____ day
of _____, 20____.

Notary Signature: _____

Print Name: _____

Notary for the State of: _____

My Commission expires: _____

(Notary Seal)

PRIVACY DISCLOSURE

South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

Other personal information collected by the Department for the licensing boards it administers is limited to such personal information as is necessary to fulfill a legitimate public purpose. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on the application may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act, and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical services.

NOTE:

Your application is good for one (1) year from the date of receipt. If all required information is not received within this one (1) year period; you must begin the application process from the beginning. This includes, but is not limited to, the application fee, transcripts, license verifications, etc.



STATE OF SOUTH CAROLINA
DEPARTMENT OF LABOR, LICENSING AND REGULATION
VERIFICATION OF LAWFUL PRESENCE IN THE UNITED STATES
AFFIDAVIT OF ELIGIBILITY



Pursuant to Section 8-29-10, *et seq.* of the South Carolina Code of Laws (1976, as amended), the Department of Labor, Licensing and Regulation must verify that any person who applies for a South Carolina license is lawfully present in the United States. Complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

The undersigned _____, of _____
(Print clearly First, Middle, and Last name) (Home Address, City, State, and Zip Code)
being first duly sworn deposes and states as follows:

Check only one box:

1. I am a United States citizen; or

2. I am a Legal Permanent Resident of the United States eighteen years of age or older; or

3. I am a Qualified Alien or non-immigrant under the Federal Immigration and Nationality Act, Public Law 82-414, eighteen years of age or older, and lawfully present in the United States.

4. Other: _____ Please submit any documentation that supports this status.

Date of Birth: _____

Alien Number: _____ I-94 Number: _____

(If you checked number 2, 3, or 4 you must attach a copy of your immigration documents. See instruction sheet for a list of accepted immigration documents.)

Section B: ATTESTATION.

I understand that in accordance with section 8-29-10 of the South Carolina Code of Laws, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall, in addition to other sanctions imposed by this State or the United States, be guilty of a felony, and upon conviction must be fined and/or imprisoned for not more than 5 years (or both).

I understand that the representations made in this Affidavit shall apply through any license(s) or renewals issued, and that I shall have an affirmative duty to immediately advise the Department of Labor, Licensing and Regulation of any change of my immigration or citizenship status.

I swear and attest the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension, or revocation of a license, certificate, registration or permit.

Signature of Affiant

SWORN to before me this _____ day of _____, 20____

Notary Signature

Print Name

Notary Public for _____

My Commission Expires: _____

INSTRUCTION SHEET FOR COMPLETING AFFIDAVIT OF ELIGIBILITY

CHECK box 1:

If you are a United States Citizen by birth or naturalization

CHECK box 2:

If you are a Legal Permanent Resident and you are not a U.S. Citizen, but are residing in the U.S. under legally recognized and lawfully recorded permanent residence as an immigrant.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

CHECK box 3:

If you are a Qualified Alien. You are a Qualified Alien if you are:

An alien who is lawfully admitted for residence under the INA.

An alien who is granted asylum under Section 208 of the INA.

A refugee who is admitted to the United States under Section 207 of the INA.

An alien who is paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year.

An alien whose deportation is being withheld under Section 243(h) of the INA (as in effect prior to April 1, 1997) or whose removal has been withheld under Section 241(b)(3).

An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980.

An alien who is a Cuban/Haitian Entrant as defined by Section 501(e) of the Refugee Education Assistance Act of 1980.

An alien who has been battered or subjected to extreme cruelty, or whose child or parent has been battered or subject to extreme cruelty.

PROVIDE A COPY OF ALL IMMIGRATION DOCUMENTS.

ACCEPTED IMMIGRATION DOCUMENTS:

Unexpired Reentry Permit (I-327)

Permanent Resident Card or Alien Registration Receipt Card With Photograph (I-551)

Unexpired Refugee Travel Document (I-571)

Unexpired Employment Authorization Card Which Contains a Photograph (I-766)

Machine Readable Immigrant Visa (with Temporary I-551 Language)

Temporary I-551 Stamp (on passport or I-94)

I-94 (Arrival/Departure Record) in Unexpired Foreign Passport

I-20 (Certificate of Eligibility for Nonimmigrant, F-1, Student Status)

DS2019 (Certificate of Eligibility for Exchange Visitor, J-1, Status)



PHOTOGRAPH WITH CHARACTER VOUCHER FORM

Attach a 2x2 Passport style photo
 (Polaroid or snapshot photos are not acceptable)

 Applicant Signature

 Print Name

 Date

Character Voucher A (Pharmacist 1)

I hereby certify I am a licensed pharmacist in good standing in the State of _____, my license number is: _____.

I hereby witness the above picture is a true likeness of the applicant whose signature appears above.

I further certify that I have been personally acquainted with _____ for _____ (Name of applicant) _____ (Months/year(s)) and that to the best of my knowledge,

he/she is of good moral character and is not addicted to the use of alcohol or narcotic drugs so as to render him/her unfit to practice pharmacy. I hereby recommend him/her as worthy to be licensed to practice pharmacy in South Carolina.

Remarks: _____

Signature: _____

Print Name: _____

Address: _____

City, State, & Zip: _____

Date: _____

Character Voucher B (Pharmacist 2)

I hereby certify I am a licensed pharmacist in good standing in the State of _____, my license number is: _____.

I hereby witness the above picture is a true likeness of the applicant whose signature appears above.

I further certify that I have been personally acquainted with _____ for _____ (Name of applicant) _____ (Months/year(s)) and that to the best of my knowledge,

he/she is of good moral character and is not addicted to the use of alcohol or narcotic drugs so as to render him/her unfit to practice pharmacy. I hereby recommend him/her as worthy to be licensed to practice pharmacy in South Carolina.

Remarks: _____

Signature: _____

Print Name: _____

Address: _____

City, State, & Zip: _____

Date: _____



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CERTIFICATION OF CLINICAL EXPERIENCE

This is to certify that _____ has completed _____ hours of clinical
(Name of Intern)
pharmacy training approved by the College of Pharmacy at the _____
as a prerequisite to being granted the degree of _____.

Date

Signature of Dean

Up to 1000 hours of practical experience credit may be given upon completion of a Pharm.D. degree, consisting of six or more years of collegiate studies for clinical externship.

This form must be completed and returned at the end of the Clinical Training period to:

South Carolina Board of Pharmacy
110 Centerview Drive
Columbia, SC 29210

IT IS THE SOLE RESPONSIBILITY OF THE INTERN TO ENSURE THAT THIS NOTIFICATION IS COMPLETED AND RETURNED TO THE BOARD. LACK OF KNOWLEDGE DOES NOT CONSTITUTE AN ACCEPTABLE EXCUSE.