



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) 664-4809 Fax: (670) 664-4814
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Website: cnmibpl-hcplb.net



General Information

Completion of the Application Forms

Help us to do a good job processing your application. Type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application. Remember, you are certifying that the information is truthful and correct. Make sure all documents are originals or a certified or notarized true copy of original documents. Provide all documents requested in the application; incomplete applications will delay processing. Application fees must accompany applications before initial review can begin.

Each question in the application must be answered. Attach separate sheets of paper, labeled with your name and signed by you, for any question for which you provided a "yes" response.

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if the board subsequently issues you a license.

The application cannot be altered, changed, modified or added to unless approved by the Board.

Confidentiality

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

Documents sent by Fax or Email

Fax copies or documents sent via email are not accepted for documentation or verification in our licensing process. If copy of document is sent via fax or email, the original must be sent via U.S. Postal Service to the Board's office.

Foreign Language Documents

All documents submitted in a foreign language shall be accompanied by an accurate translation in English. Each translated document shall bear the affidavit of the translator certifying that the translator is competent in both the language of the document and the English language and that the translation is a true and complete translation of the foreign language original, and sworn to before a notary public. Translation of any document relative to a person's application shall be at the expense of the applicant.

Personal Interviews

Applicants for licensure may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

Processing Time

In general, average processing time for a permanent license is 4 – 6 weeks. Application processing time depends to a large extent on the response time from other organizations, our workload and the volume of applications being processed.

License Renewal

All licenses issued by the Board expired every two years following its issuance or renewal and becomes invalid after that date. Notification for license renewal is mailed or emailed to licensees at least sixty (60)

days before the expiration date. You are required by regulations to keep your current address on file with the Board. There is a late fee of \$25.00 charged for every 1st of the month after the expiration date. Licenses, which have expired for failure to renew on or before the date required may be reinstated within one year of the expiration date. Each licensee whose license has expired and lapsed for more than one year by failure to renew must file a new application, meet present day requirements for licensure, and receive board approval.

License Denial

If for any reason you are denied the license you are applying for, you are entitled to a hearing pursuant to the Commonwealth Administrative Procedures Act, 1 CMC § 9108-15.

Abandonment of Application

Your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for one (1) year. If the application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

Pharmacist Licensure

To obtain a license to engage in the Practice of Pharmacy as a Registered Pharmacist, an applicant for licensure by examination shall:

1. Have submitted a written application in the form prescribed by the Board;
2. Have attained the age of majority;
3. Be of good moral character;
4. Have graduated and received the first professional degree from a college or school of Pharmacy accredited by the American Council on Pharmaceutical Education or other institution approved by the Board or;
5. Have graduated from a foreign college of Pharmacy, completed a transcript verification program, taken and passed a college of Pharmacy equivalency examination program, and completed a process of communication-ability testing as defined under the National Association of Boards of Pharmacy (NABP) regulations so that it is ensured that the applicant meets standards necessary to protect public health and safety;
6. Have submitted a notarized copy of the Pharmacist's license to practice Pharmacy in any state of the United States of America or any province in Canada;
7. Have submitted a signed statement indicating any information regarding any disciplinary proceedings pending or disciplinary actions taken by any state against the license including, but not limited to any conviction or revocation of license related to the practice of pharmacy, drugs, drug samples, wholesale or retail drug distribution, or distribution of controlled substances;
8. Have submitted a current report from the National Practitioner Data Bank (NPDB), the American Association of Health Systems Pharmacists, or any other entity having information pertinent to the applicant's performance;
9. Have submitted proof of the applicant to be a U.S. citizen or is lawfully entitled to remain or work in the Commonwealth;
10. Have submitted a 2" x 2" photograph of the applicant for identification purposes;
11. Have submitted any other information the Board may require to investigate the applicant's qualifications for licensure.

An application for licensure for a pharmacist shall be made under oath on forms provided by the Board and shall not be considered complete unless accompanied by the required documentation and fees, which shall not be refunded.

Any requirement that the Board is required to provide notice to the applicant shall be deemed met if such notice is sent to the address on file with the Board.

Any change in the application or of any information filed with the Board shall be reported to the Board, in writing, within ten (10) days of the change.

Application submitted to the Board shall remain active for period of six (6) months from the date it is received. After this time period, incomplete application will then automatically be denied.

Qualifications for Temporary License

To obtain a temporary license for Pharmacist, which shall not exceed ninety (90) days or other time period approved by the Board, an applicant shall:

1. Have submitted an application in the form prescribed by the Board;
2. Have obtained the age of majority;
3. Have good moral character;
4. Have possessed at the time of initial licensure as a pharmacist all qualifications listed in §140-50.3-3520;
5. Submit a notarized copy of a current and valid license to practice pharmacy from any state in the United States or any province in Canada;
6. Have paid the fees specified by the Board.

Schedule of Fees

Application Fee	\$100.00
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License Fee

Pharmacists	\$200.00
Temporary License Fee	\$100.00

Renewal License Fee

Pharmacists	\$200.00
Delinquent Fee (each month)	\$25.00
Replacement of License	\$75.00
Replacement of Card	\$25.00
Verification of License	\$25.00
Letter of Good Standing	\$25.00



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

APPLICATION FOR PHARMACIST

<input type="checkbox"/> Initial	<input type="checkbox"/> Endorsement	<input type="checkbox"/> Temporary
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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. Color of Eyes: Color of Hair:	5. Height: Weight:	6. Sex:
7. Mailing Address:		8. Email Address:	
9. Residence Address:		10. Phone No: (W): (H):	
11. NPI # (if available):		12. Citizenship: ___ U.S. ___ Other Specify:	

13. EDUCATION – (Provide an original, notarized or certified copy of your degree)

Name of Schools	Location (City/State or Country)	Degree Earned	Dates (Mo/Yr)	
			From	To

14. EXAMINATION – (List examination(s) you have taken and passed)

Examination	Date	Result (Pass/Fail)

15. EXPERIENCE

Name of Place	Location (City/State or Country)	Dates (Mo/Yr)	
		From	To

16. LICENSES – (List of all jurisdiction where you are licensed or applied for a license.)

Name of Jurisdiction	Date Issued	Expiration Date	License Number	Current Status

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

If you answer “yes” for any of items 18-32 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.)

18. Have you ever been charged with, or been found to have committed dishonorable, unprofessional conduct, negligence, incompetence, misconduct, or repeated negligent acts by any licensing board, other agency, or clinic?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. 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 <input type="checkbox"/>	No <input type="checkbox"/>
20. 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 <input type="checkbox"/>	No <input type="checkbox"/>
21. Is there any ongoing or pending investigation against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22. Is there any disciplinary action pending against you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23. Has any clinic 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 <input type="checkbox"/>	No <input type="checkbox"/>

24. 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 <input type="checkbox"/>	No <input type="checkbox"/>
25. 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 <input type="checkbox"/>	No <input type="checkbox"/>
26. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
27. Have you been treated for or had a recurrence or a diagnosed addictive disorder?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
28. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice your profession safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
29. Do you have any other condition in which in any way impairs or limits your ability to practice your profession safely?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
30. 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 <input type="checkbox"/>	No <input type="checkbox"/>
31. Is criminal action pending against you in any court?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
32. Are you required to register as a Sex Offender?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

33. 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 of 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 or 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.

Signature of Applicant

Date

Please complete the application form and attach all original, certified or notarized documents and a non-refundable application fee of \$100.00 (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
