

**Junta de Farmacia de Puerto Rico**  
**Favor de llenar en su totalidad en letra de molde**

**Información Personal**

<hr/> <b>Primer Apellido</b>	<hr/> <b>Segundo Apellido</b>	<hr/> <b>Primer Nombre</b>	<hr/> <b>Inicial</b>
<hr/> <b>Seguro Social</b> <b>*Últimos 4 dígitos</b>	<hr/> <b>Fecha de Nacimiento</b> <b>dd/mm/yyyy</b>	F <input type="checkbox"/>	M <input type="checkbox"/>
<b>Ciudadanía:</b> _____			
<hr/> <b>Teléfono Celular</b>	<hr/> <b>Teléfono Hogar</b>	<hr/> <b>Teléfono Trabajo</b>	

\_\_\_\_\_  
**Correo Electrónico:** Ejemplo: user@yahoo.com

**Información de Contacto**  
**Dirección Postal**

**Examen:**

<hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> <b>LEGISLACION FARMACEUTICA</b>
<b>País, Ciudad, Código Postal</b>	

**Número de Intento:** \_\_\_\_\_  
**Institución de Procedencia:** \_\_\_\_\_ **Recinto:** \_\_\_\_\_  
**Fecha de Graduación:** \_\_\_\_\_

\_\_\_\_\_  
**Para uso de la ORCPS:**

**Certificado Permanente:** \_\_\_\_\_  
**Fecha:** \_\_\_\_\_ **Visto Bueno:** \_\_\_\_\_



## APPLICATION FOR EXAMINATION

Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
\_\_\_\_\_

Postal Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: Work \_\_\_\_\_ Residence \_\_\_\_\_ Cellular \_\_\_\_\_

Social Security Num. \_\_\_\_\_ Date of Birth \_\_\_\_\_

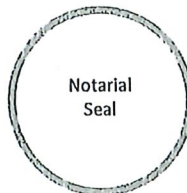
ADHIERA FOTOGRAFIA  
RECIENTE,  
AUTOGRAFIADA  
TAMAÑO PASAPORTE

### AFFIDAVIT

State \_\_\_\_\_ or \_\_\_\_\_ of \_\_\_\_\_ (territory)  
\_\_\_\_\_ country of (or  
city) \_\_\_\_\_  
says that \_\_\_\_\_ he  
(her) is the person referred to in this application and that  
the statements herein contained are true in every respect,  
and that the attached photograph is a true likeness of her  
(him) self taken within the last six months.

SUBSCRIBED AND SWORN TO BEFORE ME this \_\_\_\_\_ day of \_\_\_\_\_  
20\_\_\_\_. Witness my hand and seal hereunto attached.

AFFIDAVIT NUM.: \_\_\_\_\_



\_\_\_\_\_  
Signature of Notary Public

PERSONAL INFORMATION OF THE APPLICANT

1. Has your name ever been changed? Yes \_\_\_\_\_ No \_\_\_\_\_  
If so, give date and place of such change \_\_\_\_\_  
Give the original name \_\_\_\_\_
2. Place of birth \_\_\_\_\_ Age: \_\_\_\_\_
3. Are you a citizen of the United States? Yes \_\_\_\_\_ No \_\_\_\_\_ (If naturalized, give date and place of naturalization \_\_\_\_\_)
4. Have you ever practiced pharmacy illegally? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Have you ever been convicted of, or indicted for any crime? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, state facts in the case here or on separate sheet and attach \_\_\_\_\_
6. Do you suffer of any physical or mental condition? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please submit a Doctor's Certification than explain your condition at the same date of this application).
7. Do you need special accommodation? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please present evidence for this petition).

HIGH SCHOOL EDUCATION

I was graduated from the \_\_\_\_\_

High School, located at \_\_\_\_\_, Puerto Rico, on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

COLLEGE OR UNIVERSITY EDUCATION

Name and location of institution attended

Period of attendace (for example, October 1993 to May 1994)

1<sup>st</sup> year \_\_\_\_\_  
2<sup>nd</sup> year \_\_\_\_\_  
3<sup>rd</sup> year \_\_\_\_\_  
4<sup>th</sup> year \_\_\_\_\_

I have credit for \_\_\_\_\_ of college work. I received the degree of \_\_\_\_\_ from \_\_\_\_\_ on the day of \_\_\_\_\_.

I attended \_\_\_\_\_ full courses (credits) Pharmacy lectures as follows:

At \_\_\_\_\_  
from the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
to the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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At \_\_\_\_\_  
from the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
to the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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At \_\_\_\_\_  
from the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
to the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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At \_\_\_\_\_  
from the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
to the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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At \_\_\_\_\_  
from the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
to the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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At \_\_\_\_\_  
from the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
to the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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I was granted a Diploma of Doctor of Pharmacy by \_\_\_\_\_  
located at \_\_\_\_\_ state of \_\_\_\_\_  
On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

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## CERTIFICATE OF GOOD MORAL CHARACTER

(To be filled and signed by a Registered Pharmacist not related to applicant)

This certifies that I have been personally acquainted with \_\_\_\_\_ for \_\_\_\_\_ years that know him/her to be of good moral character, and that I hereby recommend him/her to the Board of Pharmacy of Puerto Rico as entirely worthy of examination for a license to practice Pharmacy pursuant to law.

\_\_\_\_\_  
NAME OF PHARMACIST

\_\_\_\_\_  
SIGNATURE OF AFFIANT

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Graduated in the year \_\_\_\_\_ of \_\_\_\_\_ License No.

\_\_\_\_\_ Issued by \_\_\_\_\_.



## **NON-REFUNDABLE PAYMENT**

**The following documents are considered part of this application**

- Official application for examination duly fulfilled
- Original and copy of the College of Pharmacy Diploma
- Official transcript of subjects and grades in pharmacy, must be requested from the College of Pharmacy to be sent directly to the Board of Pharmacy of Puerto Rico, at the following address:

**Office of Regulations and Certification of Health Professionals  
P.O. Box 10200  
San Juan, Puerto Rico 00908-0200**

- Certification issued by the register of the university where you obtained your degree of Bachelor in Pharmaceutical Sciences, showing that you completed such degree and the date of graduation.
- Birth Certificate (Original and copy)
- Certificate of Penal Record, issued by the Department of Police (Original)
- Health Certificate – From a Public Hospital or Private Physician
- Postal Money Order or Certified Check payable to the Secretary of Treasure of Puerto Rico on the amount of \$200.00 or ATH, VISA or MASTERDARD (local examination).
- Only the Puerto Rico University and the universities recognized by the American Council on Pharmaceutical Education are approved by this Board.
- All information requested in this application must be submitted.
- Postal Money Order or Certified Check payable to **Didaxis** on the amount of \$75.00. You can also pay by ATH, VISA or MASTERCARD. CASH OR PERSONAL CHECKS IS NOT ACCEPTED. Payment centers are the following:

Didaxis Centro Metro, Club Rotario de Río Piedras, Urb. Caribe, 1609 Calle Ponce de León  
Carr. Núm. 1 de Río Piedras, P.R. 00928. Tel. (787) 223-1133. [www.didaxispr.com](http://www.didaxispr.com).

- Criminal Record Certificate (ORIGINAL) issued by the Puerto Rico Police with no more than one (1) months prior to the requested test.
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### **National Association of Board of Pharmacy Licensure Examination (Naplex)**

- Postal Money Order or Certified Check payable to the Secretary of Treasure of Puerto Rico on the amount of \$500.00.

**NOT BE ACCEPTED INCOMPLETE APPLICATIONS OR AFTER THE DATE LIMIT**