State of South Dakota
Board of Pharmacy
4001 W. Valhalla Blvd., Suite 106
Sioux Falls, SD 57106
P – 605.362.2737 F - 605.362.2738
E – pharmacyboard@state.sd.us

Application for Reinstatement as a Pharmacist in South Dakota

Name: _____ _____ _____ _____
Last First Middle Maiden

Mailing Address: _____

City _____ State _____ Zip Code: _____

Phone Number (___) _____ Email: _____

Date of Birth: _____ **South Dakota Pharmacist License Number** _____

Social Security Number: _____ **Last Year Licensed in South Dakota** _____

Other states where you are you licensed as a pharmacist (please include certificate number) _____

_____

Submit Items 1-3 With Application

1. Payment of $125 for each year your SD license was inactive (to maximum of 10 years). Check payable to the SD Board of Pharmacy. Calculate payment starting from the expiration date of your last SD license.

Expired			
9/30/2019	$125	9/30/2023	$125
9/30/2020	$125	9/30/2024	$125
9/30/2021	$125	9/30/2025	$125
9/30/2022	$125	9/30/2026	$125

2. One-time late fee of $50.00. Check payable to the SD Board of Pharmacy.
3. 12 hours of CE completed within the last 24 months.

After application submission and review, the board may require you:

- Complete the South Dakota MPJE exam
- Provide copies of your current registered pharmacist licenses
- Complete a background check
- Provide work history

FOR SD BOP USE ONLY

Received _____ Check # _____ Amount _____ Approved _____ Issued _____

Revised 7.25

Continuing Education Form

To qualify for reinstatement, a pharmacist must complete 12 hours of continuing education (CE). The 12 hours of CE must be completed within the last 24 months. If the pharmacist applicant has a certificate to administer immunizations, one hour of the required 12 hours must be related to immunizations. ARSD 20:51:19.03.

CE Program Name	CE Program Location	CE Program Date	Hours Earned

Record of Charges, Convictions, and Discipline

Answer Yes or No to the following. If you answer "Yes" to questions 1-7, on a separate paper provide a complete description of the dates and circumstances and provide supporting documentation. If you answer "No" to questions 8-9, provide an explanation.

1. Since your last renewal, have you been convicted, plead guilty or no contest, or received a suspended imposition of sentence for a felony or other criminal offense (excluding minor traffic violations)? _____
2. Is there any pending criminal prosecution against you which would constitute a felony? _____
3. Since your last renewal, has your license to practice pharmacy in any jurisdiction been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary actions? _____
4. Are you currently being investigated or the subject of pending disciplinary actions? _____
5. Do you currently have a condition related to alcohol or substance use that impairs your ability to practice pharmacy safety and competently? _____
6. Do you currently have a physical, mental, or emotional condition that impairs our ability to practice pharmacy safely and competently? _____
7. Do you have child support arrearages in the sum of $1,000 or more? _____
8. Do you follow the Rules of Professional Conduct as outlined in ARSD 20:51:16? _____
9. I attest that I am aware of the presence and availability of the Health Professionals Assistance Program. _____

Affidavit – this section must be completed in the presence of a notary public.

I, the undersigned, being duly sworn, say that I am the person referred to in the foregoing application, and I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature of Applicant_____

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

NOTARY SEAL

Signature of Notary Public_____

Notary for the State of _____ My commission expires_____