Per Rule §15-1-14.4.2 renewal applications must be RECEIVED in our office by June 15th in order to allow time to process by June 30th
All renewal applications RECEIVED in our office after June 30th will be required to pay a late fee

West Virginia Board of Pharmacy
1207 Quarrier St. 4th Floor
Charleston, WV 25301

APPLICATION FOR LICENSE RENEWAL AS A REGISTERED PHARMACY TECHNICIAN

July 1, 2025 to June 30, 2027

Section 10, Article 5, Chapter 30 of the Code of West Virginia requires that every registered pharmacy technician within this state shall on or before July 1 apply to the State Board of Pharmacy for annual renewal of his or her certificate. Complete the following form; fill in all categories as required, return with the fee of **$30** payable to the West Virginia Board of Pharmacy by **check or money order only.** Applications received in the Board Office after June 30 requires payment of a late fee of $20.00 in addition to your regular renewal fee, to total $50.00. If you fail to submit your application for renewal by August 31, your authorization will be considered lapsed. If lapsed, you will have to apply for reinstatement using the appropriate reinstatement application.

Since last renewal, have you been convicted of any felony or infraction of pharmacy laws? ___Yes ___No

Since last renewal, have you been subject to discipline or are you currently under investigation for discipline by any Board of Pharmacy or other professional licensing agency in this or any other state or U.S. territory or jurisdiction? ___Yes ___No

If you answered yes to either of these questions, please attach a brief explanation of the charges/circumstances and the resolution

1. Were you licensed prior to July 1, 2014? ____Yes ____ No
   If Yes, Continue
   If No, Provide copy of your national certification from PTCB or NHA (EXCPT)
2. Have you let your license lapse for over 1 year? ____Yes ____No
   If Yes, Provide copy of your national certification from PTCB or NHA (EXCPT)
   If No, by signing, I certify that I have not let my license lapse for over 1 year. ________________________________
3. Are you trained to be an Immunizing Pharmacy Technician? ____Yes ____No
   If Yes, Please attach proof of APhA Pharmacy Technician Immunization Training or other Board approved training certificate, proof of current Board approved CPR training **and** Proof of 2 hours of CE.

Name and Address Corrections on lower half: ___Yes ___No

Current Name & Address:

Name and Address of your employer below this line:

License #:PT000____________________

County:________________________ SSN:_____-_____-________ Date of Birth___/___/______Gender_____M___F

E-Profile #: ______________________________ Email: ____

Phone #(H):________________________________ Phone #(W): ________________________________

Signature:____ Date:______________________

Name and Address Changes:

Name: ____

Address: ____

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