

INSTRUCTIONS FOR FILING

Application for Registration – Pharmacy Technician

Access this form via website at: cca.hawaii.gov/pvl

IMPORTANT INFORMATION

LAWS & RULES PUBLICATION

The Pharmacists and Pharmacy laws and rules, Hawaii Revised Statutes (HRS) 461, Hawaii Administrative Rules (HAR) 16-95, are posted on our website at: cca.hawaii.gov/pvl. Click on "Pharmacy and Pharmacist." HRS 436B, the Professional and Vocational Licensing Act, is also available.

AUTHORIZATION TO ADMINISTER VACCINES

Pursuant to HRS §461-11.4 and Act 93, if you intend to administer vaccinations authorized or approved by the United States Food and Drug Administration (FDA), under the supervision and ordered by a Hawaii registered pharmacist, and in accordance with the recommendations of the Advisory Committee on Immunizations Practices of the United States Department of Health and Human Services, then you will need to complete the separate submission form from the board's website (<https://cca.hawaii.gov/pvl/boards/pharmacy/>).

AGE OF MAJORITY & AUTHORIZATION TO WORK IN THE U.S.

Applicants shall be beyond the age of majority (18 years old) and a United States citizen, a United States national, or an alien authorized to work in the United States. If you are not a U.S. citizen, or U.S. national or an alien authorized to work in the U.S., your application may be denied.

SOCIAL SECURITY NUMBER

Your Social Security Number is used to verify your identity for licensing purposes and for compliance with the below laws. **For a license to be issued you must provide your Social Security Number or your application will be deemed deficient and will not be processed further.**

The following laws require that you furnish your Social Security Number with our agency:

FEDERAL LAWS

42 U.S.C.A. §666(a)(13) requires the Social Security Number of any applicant for a professional license or occupational license be recorded on the application for license; and

If you are a licensed health care practitioner, 45 C.F.R., Part 61, Subpart B, §61.7 requires the Social Security Number as part of the mandatory reporting we must do to the Healthcare Integrity and Protection Data Bank (HIPDB), of any final adverse licensing action against a licensed health care practitioner.

HAWAII REVISED STATUTES

HRS §576D-13(j) requires the Social Security Number of any applicant for a professional license or occupational license to be recorded on the application for license; and

HRS §436B-10(4) states that an applicant for license shall provide the applicant's Social Security Number if the licensing authority is authorized by federal law to require the disclosure (see "federal laws" section above).

REGISTRATION DENIAL

If for any reason your registration is denied, you may be entitled to a hearing as provided by HAR 16-201 and/or HRS Chapter 91. Your written request for a hearing must be directed to the agency that denied your application and must be made within 60 days of the notification that your application for registration has been denied.

APPLICATION FORM

Complete the online fillable form or print legibly in dark ink. Answer ALL questions and sign the application.

***Please be advised that failure to provide all the requested information will delay the processing of your application.**

FEES

Make checks payable to: COMMERCE AND CONSUMER AFFAIRS. Check must be made in U.S. dollars and be from a U.S. financial institution.

If your registration will take effect in an EVEN-NUMBERED year, pay \$130
(Application - \$20**, Registration - \$10, Compliance Resolution Fund - \$100)

If registration will take effect in an ODD-NUMBERED year, pay \$80
(Application - \$20**, Registration - \$10, 1/2 Compliance Resolution Fund - \$50)

****Application fee is not refundable.**

The Compliance Resolution Fund, authorized by HRS 26-9(o), was established to ensure compliance with applicable licensing and consumer laws.

NOTE: *Payment of fees as set forth in this application is required for your registration to be issued. If payment is dishonored by your bank, your registration will not be valid, and you **may not** do business under that registration. A \$25.00 service charge shall be assessed for payments that are dishonored for any reason.*

**"YES" RESPONSE(S)
TO QUESTIONS
#4 or #5**

Questions **(4)** and **(5)** on the Application for Registration form (PHT-01) refer to complaints, charges of unlicensed activity, or pending disciplinary actions for any profession, occupation, or license, and you must submit the following:

- A statement signed by you explaining the circumstances in detail; and
- Copies of any documents from the licensing authority, including final orders, petitions, complaints, findings of fact and conclusions of law, and any other relevant documents.

**"YES" RESPONSE
TO QUESTION #6**

Question **(6)** refers to criminal convictions that have not been annulled or expunged, and you must submit the following:

- A detailed statement signed by you explaining the circumstances leading to the conviction and detailing all activities since the conviction, including employment and business involvements. Include job title, period of employment, employer's name, description of duties, training attended, and educational courses attended;
- A copy of the court order, verdict, and terms of sentence; and
- If applicable, a copy of the terms of probation and/or parole and a statement from your probation or parole officer as to your compliance with the court orders; and
- A current criminal history record check in your name from the state where the conviction occurred and the state where you currently reside, if different. In Hawaii, you may obtain a criminal history record check from the Hawaii Criminal Justice Data Center. Contact the Department of the Attorney General, Hawaii Criminal Justice Data Center, Kekuanaoa Building, 465 S. King Street, Rm. 101, Honolulu, HI 96813. Ph: (808) 587-3100 or visit their website at: www.hawaii.gov/hcjdc to request a "Criminal History Record Check" form.

Your application may be reviewed at a Board of Pharmacy meeting if you answered "Yes" to questions **(4)**, **(5)**, or **(6)**, and if you have provided all applicable information and documents as described above. The Board will not review incomplete applications. If you wish to present oral testimony at the meeting, submit a written request with your application.

**RELEASE OF
INFORMATION**

If an agency or individual is assisting you with the licensure process, we will not be able to release any information to them unless you provide us with authorization. If you wish to do so, please complete the **"Release of information to Third Party"** portion on the application, sign, and date it.

**ABANDONMENT
OF APPLICATION**

Pursuant to HRS §436B-9, your application shall be considered abandoned and will be destroyed if you fail to complete the application process within one year after filing an application.

If an application is deemed abandoned, the applicant shall be required to reapply for registration and comply with the registration requirements at the time of the reapplication.

**BOARD'S
ADDRESS**

Mail all required items to:

Board of Pharmacy
DCCA, PVL Licensing Branch
P.O. Box 3469
Honolulu, HI 96801

Deliver to office location:

335 Merchant St., Room 301
Honolulu, HI 96813
OR
Phone: (844) 808-DCCA (3222)

(CONTINUED ON NEXT PAGE)

APPLICATION FOR REGISTRATION – Pharmacy Technician

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READ THE INFORMATION & INSTRUCTIONS BEFORE COMPLETING THIS FORM.

Legal Name (First, Middle) (Last)		<input type="checkbox"/> Approved Initials/Date: <input type="checkbox"/> Denied Reg. No.: _____ Eff. Date: _____	
Other Names Used (including maiden name) Date of Birth			
Residence Address (include Apt. No., City, State & Zip Code) - REQUIRED		FOR OFFICE USE _____	
Mailing Address (ONLY if different from residence)	Social Security No. _____		
	Phone No. (days) _____		
	Email Address _____		

Please answer the following questions by checking the appropriate box YES or NO:

1. Are you at least 18 years of age? YES NO
2. Are you a U.S. citizen, a U.S. national, or an alien authorized to work in the U.S.? YES NO
3. Have you ever held a pharmacy technician registration in any state or territory of the U.S.? YES NO

List all State(s)/Territory(ies) with original issuance date: _____

4. Has any registration/certification/license ever been suspended, revoked or otherwise subject to disciplinary action? YES NO
5. Are there any disciplinary actions pending against you? YES NO
6. Have you ever been convicted of a crime in any jurisdiction that has not been annulled or expunged? YES NO

If you responded "Yes" to #4, #5, or #6, you will be required to submit additional documentation. Please see instructions for more information. Failure to provide the requested information will delay the processing of your application.

Declaration of Applicant:

I hereby certify that the answers and statements on this application and documents attached are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of registration pursuant to HRS 436B-19 and 461-21, and is a misdemeanor pursuant to HRS 710-1017. I further certify that I have read, understand, and will abide by the provisions of HRS Chapters 461 and 436B, HAR 16-95, and Act 93 (2025).

Signature of Applicant

Date

Release of Information to Third Party:

To assist me in the registration process, I hereby authorize the Board of Pharmacy and staff to release any and all information regarding my application(including, but not limited to, application status) to the following third party:

Print name of Individual who is assisting you: _____

Name of Organization: _____

Signature of Applicant

Date

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (844) 808-DCCA (3222) to submit your request.

App	496.....	\$ 20
Reg	504.....	\$ 10
CRF.....	497.....	\$ 50/100
BCF.....		\$ 25