

**PRECEPTOR**

(Expires June 30 of odd years)  
Oregon Board of Pharmacy  
800 NE Oregon Street, Suite 150  
Portland OR 97232

[Pharmacy.Licensing@bop.oregon.gov](mailto:Pharmacy.Licensing@bop.oregon.gov)



FOR BOARD USE ONLY

PERSON ID # \_\_\_\_\_

APPLICANT ID # \_\_\_\_\_

**PRECEPTOR APPLICATION**

A Preceptor is responsible for the supervision of the majority of the Intern’s hours by working directly with the Intern and college or school of pharmacy. Please do not submit an application unless you are willing and able to do this. All Preceptor licenses expire June 30th of odd years. If you are an Oregon licensed Pharmacist, your Preceptor license will be renewed concurrent with your Pharmacist license.

**To apply for a Preceptor license, you will need to provide the following documentation:**

- **Completed Application**
- **Photo Identification – Forms of acceptable identification are:**
  1. A color copy of the front and back of your state issued photo ID **OR**
  2. A color copy of your signed Passport. If you were born outside the United States, you can submit a color copy of your country passport and work visa, country passport and Employment Authorization Document (EAD), or country birth certificate and naturalization document or residency card.
- **If applicable:**
  1. Proof of current active participation in an ASHP-accredited, pre-candidate, candidate or conditional accredited PGY1 residency
  2. Proof of license in good standing with applicable healthcare Board or Regulatory Agency (copy of online license verification will be accepted)

Please check one:  New Application  Preceptor Reinstatement Application

**REQUIRED INFORMATION**

**NOTE:** The furnishing of false information is grounds for discipline, including license denial.

Full Legal Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number - Home: \_\_\_\_\_ Phone Number - Cell \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

E-mail Address(s): \_\_\_\_\_

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

Employer Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Start Date: \_\_\_\_\_

If you are a pharmacist in a **FEDERAL FACILITY** or a **NON-PHARMACIST**, you are still required to be licensed as a Preceptor with the Oregon Board of Pharmacy. An application cannot be processed until all the information requested below is provided.

Please check one:  Pharmacist Preceptor  Healthcare Preceptor  Other Preceptor

OCCUPATION/PROFESSION \_\_\_\_\_

DEGREE (RELATED TO THE ACADEMIC DISCIPLINE FOR WHICH YOU WILL PRECEPT):  
\_\_\_\_\_

FOCUS OF INTERN SUPERVISION/TRAINING \_\_\_\_\_

SCHOOL OF PHARMACY AFFILIATION \_\_\_\_\_

SCHOOL OF PHARMACY CONTACT NAME & EMAIL \_\_\_\_\_

LICENSE NUMBER (if applicable) \_\_\_\_\_

NAME OF LICENSING AGENCY (if applicable) \_\_\_\_\_

- Has any disciplinary action been taken against your health-related profession license, certificate, or registration in any state, US jurisdiction, or foreign authority?  No  Yes
- Have you had any health-related profession license, certificate, or registration denied or revoked, in any state, US jurisdiction, or foreign authority?  No  Yes

If "Yes" to either question above, you must provide a copy of your Board or Regulatory Agency Disciplinary Orders. If orders were issued by the Oregon Board of Pharmacy, provide the case number: \_\_\_\_\_ - \_\_\_\_\_

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*I attest, under the penalties of perjury, that:*

- *I meet the qualifications for licensure as a Preceptor as listed in [OAR 855-120-1010](#)*
- *I have read and agree to abide by the laws and rules of the Oregon Board of Pharmacy, Oregon Revised Statutes Chapters [ORS 475](#) and [ORS 689](#) as well as Oregon Administrative Rule [Chapter 855](#). The rules specific to Interns and Preceptors are found in [OAR 855-120](#).*
- *I am aware that failure to observe these statutes and rules may result in imposition of a civil penalty, revocation, and other action against my license.*

*By submission of this application, I do solemnly swear or affirm that I have personally completed this application, and that the information provided is true and correct to the best of my knowledge. I understand that if my application is incomplete and I do not submit all of the required documentation within 90 days from the date this application is submitted, I will be required to complete a new application to continue the licensure process. I am fully aware that falsifying an application, supplying misleading information or withholding information is grounds for denial or revocation of a license.*

Applicant Signature \_\_\_\_\_ Date: \_\_\_\_\_

**WARNING: [ORS 689.405](#) Grounds for discipline; investigation; procedure as contested case.**

(1) The State Board of Pharmacy may refuse to issue or renew, or may suspend, revoke or restrict the license of any person or the certificate of registration of any drug outlet upon one or more of the following grounds:

(f) Fraud or intentional misrepresentation by a licensee or registrant in securing or attempting to secure the issuance or renewal of a license.



## **Applicant Record Notification**

### **Signature Acknowledgment Form** ***(this page must be returned with application)***

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#### **USE OF YOUR SOCIAL SECURITY NUMBER:**

The Oregon Board of Pharmacy is required, under [42 USC § 666\(a\)\(13\)](#) and [ORS 25.785](#) to obtain the social security numbers of all licensees. Your social security number may be used for purposes of identification, to conduct a background investigation, and debt collection efforts. The Board may disclose your social security number to the following entities: the Oregon Department of Justice; the Oregon Department of Revenue, the National Association of Boards of Pharmacy; the National Practitioner Databank; other state boards of pharmacy; law enforcement agencies and collection firms. Failure to provide your SSN will result in non-licensure.

- If you do not have a SSN Number, please provide a copy of your Passport and U.S. Visa showing you are entitled to work in the United States (i.e., H1B Visa). If you are attending school on an F1 Visa, please provide a copy of your I94 and I20 which has been signed by your Designated School Official.

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#### **DISCLOSURE OF PERSONAL INFORMATION:**

The Oregon Board of Pharmacy makes every effort to protect the personal information you provide. The information you provide, however, may be disclosed in the following circumstances:

- In response to a Public Records Request
- To another government agency as allowed by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

Once you are licensed with the board, the address of record you enter on this application is considered public information and your city and state will be placed on the Internet. If you do not wish for your physical / residence address to be available to the public, you may provide a post office box number or a private mailbox. However, if your address of record is not your physical/residence address, you must also provide your physical / residence address to the board, in which case your physical / residence will not be available to the public.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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