



District of Columbia
DEPARTMENT OF HEALTH – HEALTH REGULATION AND LICENSING ADMINISTRATION
PHARMACEUTICAL DETAILER RENEWAL APPLICATION

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Please read instructions at the beginning of each section as you complete this form. See Section 2 for special instructions specific to your license. If you have any questions, call HPLA's toll-free Customer Service line Monday through Friday, 8:15AM to 4:45 PM EST at 1-877-672-2174. *A Charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)*

SECTION 1. LICENSEE INFORMATION – Carefully review all demographic information in this section. Please make all name, address, SSN, and birth date corrections in Sections 4 on Page 2.

PRINT Full Name & home address: _____ License Number: _____
 *SSN: _____
 Birth date: _____
 Business Address: _____

Phone: _____ Phone: _____
 Fax: _____ Fax: _____
 E-mail: _____ E-mail: _____

Please select your preferred mailing address;

Home Business

*Pursuant to D.C. Official Code Section 3-1205.5 (b) (2001) (HORA), applicants are required to provide a Social Security Number (SSN) on licensure applications.

SECTION 2. SPECIAL INSTRUCTIONS

- Your registration expires this upcoming February 28th 2016
- Each applicant for renewal of a license, registration, or certification shall obtain State and FBI criminal background checks. A licensee, registrant, or certification holder shall be required to undergo a subsequent criminal background check every four (4) years from the date of the licensee's registrant's or certification holder's previous background check.
- Further information regarding criminal background check can be obtained at <http://doh.dc.gov/service/criminal-background-check>.
- Renewal applications submitted after February 28th will be required to pay an \$85.00 late fee.
- You must complete required continuing education by February 28, 2016. **NOTE: Indicating that you completed the required continuing education hours if you have not, subjects you to disciplinary action.**
- If you answer "Yes" to questions A through J in Section 6, your license will not be renewed until your supporting documentation has been received.
- If you are unable to renew your registration by February 28th or within the 60-day late renewal period, you will then be required to apply for reinstatement of your registration.
- You may reinstate your registration in the District within 5 years of the expiration date of your registration. Once the 5-year reinstatement period has ended, you must apply as a new applicant. You will receive a new registration number upon approval.

Continuing Education Requirement: Pharmaceutical Detailers must complete fifteen (15) hours of continuing education between the licensing period of March 1, 2014-February 28, 2016.

Online Renewal Instructions: To renew your license online go to: www.hpla.doh.dc.gov. Enter your Social Security Number and Last Name, then go to the next screen and enter your User ID and Password.

Keep a copy of this renewal form and your payment for your records. Remember that you are required by law to notify HPLA of any address changes within 30 days of the change. You may send address changes to the address below. This will help ensure that you receive your next renewal notice in a timely manner

SECTION 3. LICENSE RENEWAL AND FEES – Select the type of action you wish to take for your license.

Please check the appropriate box (es).

	FEE	
A. <input type="checkbox"/> Renewal fee	\$ 175.00	_____ .00
D. <input type="checkbox"/> Paid Inactive Status	\$175.00	_____ .00
E. <input type="checkbox"/> Late fee (if received after due date)	\$ 85.00	_____ .00
F. <input type="checkbox"/> Deceased * (see notes)	\$ 0.00	_____ .00
G. <input type="checkbox"/> Duplicate Licenses	qty: ____ X \$34.00	_____ .00

Reactivate (Paid Inactive License) Submit Reinstatement Application

Total Enclosed \$ _____ .00

Make check or money order payable to
DC Treasurer and mail to:
 Department of Health/HPLA
 Board of Pharmacy-DT Renewal
 P.O. Box 37801
 Washington, DC 20013
 Phone: 1-877-672-2174; Fax: (202) 724-5145

www.hpla.doh.dc.gov Email: hpla@dc.gov

**YOU MAY RENEW UNTIL:
 February 28, 2016**

Notes:

* If the licensee is deceased, please return the application to the address above along with a death certificate or notarized letter indicating that the licensee is deceased.

SECTION 4. NAME CHANGE

If you are changing your name, you must provide legal documentation of the name change. Acceptable documentation for individuals includes a copy of marriage certificate, divorce decree, or court order. Changed to current name by: Marriage Divorce Court Order

FIRST NAME	MI	LAST NAME	SUFFIX (Jr, Sr, etc.)
M M D D Y Y Y Y			
DATE OF BIRTH CORRECTION	SSN CORRECTION * (Required)		

SECTION 5. SECONDARY BUSINESS ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME			
<input type="checkbox"/> APARTMENT	<input type="checkbox"/> SUITE	<input type="checkbox"/> FLOOR	<input type="checkbox"/> PO BOX NUMBER
BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)			
BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)			
CITY		E-MAIL	
STATE	ZIP CODE + 4	BUS PHONE NUMBER	BUS FAX

SECTION 6. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer questions A through H by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through J below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant court documents, and attach to this form.

A.	<p>Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.</p> <p>Please read the information below carefully before responding to this yes or no question, as any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).</p> <p>IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR APPLICATION BE DENIED.</p> <p>As of this date, do you owe more than one hundred dollars (\$100) to the District of Columbia Government as a result of any of the following:</p> <ol style="list-style-type: none"> 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985); 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994); 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985); 4. Past due taxes; 5. Past due District of Columbia Water and Sewer Authority service fees; or 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)? <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the <i>Clean Hands Before Receiving a License or Permit Act of 1996</i>, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.)</p>		
B.	Since your last application, have you been arrested, convicted or charged for a felony or misdemeanor including DUI, OWI, DWI's (other than minor traffic violations for which a fine or ticket is the maximum penalty)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
C.	Since your last application, have you withdrawn an application for licensure/certification/registration to practice any health profession in any jurisdiction?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
D.	Since your last application, have you been involved in a malpractice suit? If yes, provide date of the incident, and disposition of case.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
E.	Since your last application, have you been or are you currently being investigated by any authority or peer review board for any violation of state, federal, or local law?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
F.	Since your last application, has any authority, health facility or peer review board taken action against any of your health profession licenses or privileges (including imposing a fine, sanctions, censure or reprimand, probation, imposition of restrictions, suspension or revocation)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
G.	Since your last application, have you been treated for or are you currently being treated a physical or mental condition, including alcohol or drug abuse, that, but for the treatment, could impair your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
H.	Since your last application, have you been diagnosed or treated for alcohol abuse, controlled substance abuse, prescribed medication abuse, or illegal drug abuse?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
I.	Since your last application, has any authority, health facility or peer review board informed you of any pending charge(s) or investigation(s)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
J.	Since your last application, have you been terminated, asked to resign, or resigned in lieu of being terminated from employment or a clinical training/fellowship program for any health profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
K.	Do you currently practice your profession in the District of Columbia?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
L.	I certify that I have completed a total of fifteen (15) continuing education credit between the licensing period of March 1, 2014-February 28, 2016, I understand that I may be required to submit proof of Continuing Education if requested by the Board.	YES <input type="checkbox"/>	NO <input type="checkbox"/>

SECTION 7. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE

LICENSEE NAME (Please print)

DATE