STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH RELATED BOARDS
TENNESSEE BOARD OF PHARMACY
665 MAINSTREAM DRIVE
NASHVILLE, TN 37243
PHONE: (615) 253-1299 FAX: (615) 741-2722 EMAIL: pharmacy.health@tn.gov
https://www.tn.gov/health/health-program-areas/health-professional-boards/pharmacy-board.html

APPLICATION and INSTRUCTIONS FOR A RESEARCHER LICENSE

1. All fees are non-refundable
2. All documentation and fees required to be submitted by you, must be mailed directly to:

Tennessee Board of Pharmacy
665 Mainstream Drive
Nashville, TN 37243

3. Please allow ten (10) business days for information mailed to the board's office to be received. Special courier services will not appreciably reduce the time it takes to process an application. It takes approximately eight (8) weeks for a license to be issued.
4. Upon receipt of the application, an administrative member of the Board of Pharmacy will conduct a preliminary review of the application.
5. The application **must** be reviewed and approved by the executive director of the Board of Pharmacy and the Medical Director for the Tennessee Department of Health.
6. Applications will be forwarded to a Board of Pharmacy investigator for an inspection. Upon receipt of a satisfactory inspection report, a license will be issued.
7. Once an application has been approved, please allow 7-14 business days for receipt of the license certificate.

CHECKLIST FOR LICENSE AS AN RESEARCHER

1.	**Application**: Complete the application, sign and mailed to the Tennessee Board of Pharmacy with all required documentation
2.	**Payment methods**: Make check or money order payable to the Tennessee Board of Pharmacy.
3.	**Declaration of Citizenship:** Please complete and submit along with your application the Declaration of Citizenship available online at https://www.tn.gov/content/dam/tn/health/healthprofboards/PH-41833.pdf
4.	**Competency Information:** Please read the questions in the Competency Information section of application carefully. You must answer "Yes" or "No" to **every** question. **If any of your answers to were in the affirmative, please explain the situation.** In addition to your explanation, the final documents or orders from the issuing states, courts and/or agencies must be submitted.
5.	**Protocol**: The protocol must include the name and quantity of each drug used, where the drugs will be stored, name of research and the reason (see attached)
6.	**IRB Consent/Approval Form**: Required if the applicant will be administering or dispensing prescription drugs to human subjects
7.	**Resume:** Submit a copy of your most recent resume or curriculum vitae

Application fee 9905/001- $110.00
Regulatory fee 9905/006 - $10.00

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APPLICATION FOR A RESEARCHER LICENSE

APPLICATION FOR:
□ New License
□ Location Change-TN license #_____
□ Reinstatement- TN license # _____

TYPE OF ACTIVITY
□ Scientific Research
□ Chemical Analysis

Name as it should appear on license:		
Street Address:		
Suite/Room #:		**Telephone No:**
City:	**State:**	**Zip Code:**
Name of Primary Custodian:		

Email address: _____

Do you wish to receive notifications, including renewal notification, from Department of Health via email? Please note, by opting in, all correspondence from the Department of Health will be delivered to the email address on file for you. You will no longer receive physical mail from our office. ___ Yes ___ No

If this is a new license, have you previously applied for a researcher license in Tennessee? ___ Yes ___ No

Location where drugs are stored:		
Street Address:		**Suite/Room #:**
City:	**State:**	**Zip Code:**

NATURE OF PROJECT: _____

DEA Number: _____

Type of Drugs applicant proposes to handle:

❑ Schedule I ❑ Schedule II ❑ Schedule III ❑ Schedule IV ❑ Schedule V
❑ Non-controlled substance Legend Drug(s)

Will the applicant be administering or dispensing drugs to human subjects?

❑ Yes ❑ No If yes, protocol **MUST** have specific provisions for safe administration or dispensing and method of selecting humans as well as a current IRB

If you have an NPI number, please provide: _____

Competency Information

PLEASE ANSWER THE FOLLOWING QUESTIONS. If you answer "yes" to any of the questions in this part, you must supplement your affirmative response with a thorough explanation on a separate page. IN SUPPORT OF YOUR EXPLANATION, THE FINAL DOCUMENTS OR ORDERS FROM THE ISSUING STATES, COURTS, AND/OR AGENCIES MUST BE SUBMITTED ALONG WITH THIS APPLICATION. Additional information may be requested and/or required before a licensure decision may be made. For the purposes of these questions, the following phrases or words have the following meanings:

1. "**Ability to practice your profession**" is to be construed to include all of the following:

a. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform professional tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. "**Medical Condition**" includes physiological, mental or psychological conditions including, but not limited to: orthopedic, visual, speech and/or hearing impairments, emotional or mental illness, specific learning disabilities, drug addiction, and alcoholism.

3."**Minor Traffic Offense**" generally means moving and non-moving violations punishable by fines only and does not include offenses such as driving under the influence or while intoxicated or reckless driving.

4. "**Chemical substances**" is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

5. "**Currently**" does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

6. "**Illegal use of illicit or controlled substances**" means the use of substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS: If you answer "YES" to any question, please attach a written explanation.			
		YES	**NO**
1.	Do you currently have any physical or psychological limitations or impairments caused by an existing medical condition which are reduced or ameliorated by ongoing treatment or monitoring, or the field of practice, the setting or the manner in which you have chosen to practice?	_____	____
2.	Do you currently use any chemical substances which in any way impair or limit your ability to practice your profession with reasonable skill and safety? If so, please list: _____	_____	____
[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, conditions should be imposed, or you are not eligible for licensure.]			
3.	At any time within the past two years, have you engaged in the illegal use of illicit or controlled substances?	_____	____
4.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you to assure that you do not consume alcohol and/or do not engage in the illegal use of illicit or controlled substances?	_____	____
5.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or other diagnosis of a predatory nature?	_____	____
6.	Have you ever held or applied for a license, privilege, registration or certificate to practice your profession in any state, country, or province, that has been or was ever denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	____
7.	Have you ever had staff privileges at any hospital or health care facility that were ever revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	____
8.	Have you ever applied for or held a state or federal controlled substance certificate that was ever denied, revoked, suspended, restricted, voluntarily surrendered or otherwise disciplined or surrendered under threat of restriction or disciplinary action?	_____	____
9.	Have you ever been convicted (including a nolo contendere plea or guilty plea) of a felony or misdemeanor (other than a minor traffic offense) whether or not sentence was imposed or suspended?	_____	____
10.	Have you ever been rejected or censured by a professional association or society?	_____	____
11.	In relation to the performance of your professional services in any profession: a. Have you ever had a final judgment rendered against you; b. Have you ever entered into any settlement of any legal action; or c. Are there any legal actions pending against you or to which you are a party?	_____ _____ _____	____ ____ ____
12.	Have you ever held a license, registration, privilege or certificate in any profession that has ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action in any jurisdiction?	_____	____
13.	My name has been placed on the registry of persons who have abused, neglected or misappropriated the property of vulnerable individuals (Tennessee abuse registry or an abuse registry in another state)	_____	____
14.	Has the applicant or, if the applicant is a corporation, association, partnership or other entity, has an officer, partner, or proprietor, been convicted of a felony in connection with legend drugs or controlled substances under state or federal law, or ever had a license or registration revoked, suspended or denied?	_____	____

AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a researcher in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a researcher.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without the malice concerning my competence, ethics, character, other qualifications, for certification.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

PLEASE USE THE TEMPLATE BELOW AS GUIDANCE FOR COMPLETING THE PROTOCOL TO BE SUBMITTED WITH THE APPLICATION

Protocol

I. TITLE OF PROJECT

II. STATEMENT OF PURPOSE

III. NAME AND AMOUNT OF CONTROLLED SUBSTANCE (dosage & total amount)

IV. DETAILED DESCRIPTION OF RESEARCH

V. DETAILED DESCRIPTION OF STORAGE OF CONTROLLED SUBSTANCE (Including proposed total quantities to be stored and process for removal from storage)

VI. SECURITY – All controlled substances should be secured in a vault depending on the type and amount of drug. Please contact the local DEA office for details of the vault requirements.