



State of Utah  
Department of Commerce

Division of Occupational and Professional Licensing

GARY R. HERBERT  
Governor

FRANCINE A. GIANI  
Executive Director

MARK B. STEINAGEL  
Division Director

**Notification Form for Pharmacy Technicians for Formal Programs**

**Part 1: Complete this portion for the Pharmacy Technician-in-Training:** Please list your full legal name as it appears on your driver's license, Social Security Card, etc.

Training Start Date:		Anticipated Date of Completion:	
Last Name:	First Name:	Middle Name:	
Social Security Number:    -    -	Maiden Name:		
I certify under penalty of perjury that:			
<input type="checkbox"/>	I am a citizen of the United States.		
<input type="checkbox"/>	I am a qualified alien as defined in 8 U.S.C., Sec 1641 who is lawfully present in the United States. I understand that I am required to visit DOPL's offices and present a government issued ID bearing my photo and evidence of one, or both of the following: Alien ID Number                      I-94 Number		
<input type="checkbox"/>	I have a valid Driver License or State Issued ID    State:              Number:		
<input type="checkbox"/>	I do not have a Driver License. I am legally present in the United States, and I understand that the Department of Commerce will verify my legal presence in order to process my application.		
Mailing Address:			
City:		State:	ZIP:
<input type="checkbox"/> Male	Date of Birth:	Phone:	E-Mail:
<input type="checkbox"/> Female			

**Part 2: Complete this portion for the Program that will be providing the training:**

Name of Formal Training Program:		Phone:
Mailing Address:		E-Mail:
City:	State:	ZIP:
Instructor Name(s):		
Name:	Phone:	Email:
Additional Program Contact:	Phone:	Email:
Name of Person Arranging Clinical Sites:	Phone:	FAX:
Comments:		
This form must be submitted PRIOR to beginning training of pharmacy technicians. Approval must be given by the Division before beginning a program. Training done in a non-approved program will not be given credit, and training will have to be repeated in an approved program.		

**I understand that I must complete the program and successfully pass the required examinations within one year from the date of the first day of the program.**

Pharmacy Technicians acknowledgement: \_\_\_\_\_ (signature) \_\_\_\_\_ Date: \_\_\_\_\_  
Instructors acknowledgement: \_\_\_\_\_ (signature) \_\_\_\_\_ Date: \_\_\_\_\_

Send To: **Utah Board of Pharmacy**  
**PO Box 146741**  
**Salt Lake City, Utah 84114-6741**

