

105 4/10/2015

IOWA PHARMACIST LICENSE RENEWAL APPLICATION

REMINDER: Iowa law requires a pharmacist to notify the Board within 10 days of a change of legal name, address, or employment.

Please type or print clearly in ink. Make changes as necessary.

1 License No.: 21184
Social Security No.: XXX-XX-████████

2 Name, Address:
KOLB MATTHEW
6555 W 59TH ST
CHICAGO IL 60638-

3 Iowa County: NA
Home Telephone Number: (772) 291-9949

4 E-mail address: ██████████

5 Degrees in Pharmacy: (check all that apply) ___ B.S. Pharm.D. ___ Other (specify) _____

6 List all other states in which you are currently licensed to practice pharmacy: IL, AR, FL, TN, IN, NE, NY

RECEIVED

OCT 05 2015

IOWA BOARD OF PHARMACY

LICENSE FEE: \$180.00 *

- * Fee for License renewal between July 1 and July 31: \$360.00
- * Fee for License renewal between August 1 and August 31: \$450.00
- * Fee for License renewal between September 1 and September 30: \$540.00
- * Fee for License reinstatement after September 30: \$630.00

Remit check or money order payable to:
IOWA BOARD OF PHARMACY

(DO NOT SEND CASH)

DISCIPLINARY/CRIMINAL HISTORY:

7 Since initial licensure in Iowa or another state, has your license in any state been disciplined? Discipline includes, but is not limited to, citations, reprimands, fines, license restrictions, probation, license surrender, suspension, or revocation. If yes, provide a written explanation of the discipline on a separate sheet. Provide copies of documentation from the licensing authority regarding the discipline unless complete documentation has previously been provided to this Board.
___ yes no When _____

8 Since your last license renewal application, have you been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime, other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of the conviction. For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon. Driving under the influence or driving while impaired is not a minor traffic offense and must be reported. If yes, provide a written explanation of the charge and the final outcome on a separate sheet. Provide copies of court documents related to each incident.
___ yes no When _____

CONTINUING EDUCATION:

9 Are you a **resident of AND** are you currently licensed to practice pharmacy in another state that requires continuing education for pharmacist licensure? yes ___ no If yes, State IL License Expiration Date 3-31-16
(If yes, indicate the state and license expiration date. Out of state licensure and residence combine to satisfy Iowa CE requirements UNLESS you are practicing pharmacy in Iowa. If you qualify under this provision, skip to Item 12.)

10 Is this your first license renewal following Iowa licensure by examination? ___ yes no
If yes, you are EXEMPT from Iowa's continuing education requirements for THIS RENEWAL ONLY -- skip to Item 12.
(You will be required to complete continuing education, as indicated in Item 11, on your next Iowa license renewal.)

11 ACCREDITED/APPROVED CONTINUING EDUCATION ACTIVITIES ATTENDED OR COMPLETED.

a) I hereby certify that I have completed the required 30 contact hours (3.0 CEUs) of continuing education (or alternate requirement provided by Board rules and described below) and that none of the credits relied on for this license renewal have previously been used for Iowa license renewal. I further certify that all credits relied on for this license renewal were obtained during the following 27-month license renewal period. MM (initial)

RENEWAL PERIOD: April 1, 2013, through June 30, 2015.

I hereby further certify, by initialing following each statement below, that I have completed the specific continuing education requirement or alternative indicated by the statement during the 27-month renewal period indicated.
(You may need to certify more than one statement regarding your CE activities. Initial following each statement that applies.)

b) During the 27-month renewal period indicated, I have completed a minimum of 15 contact hours of CE in ACPE-provider activities dealing with drug therapy. The ACPE universal activity number for a drug therapy activity ends with "01" or "02." Only activities with identification numbers ending "01" or "02" will be accepted to fulfill this requirement. MM (initial)

c) During the 27-month renewal period indicated, I have completed a minimum of 2 contact hours of CE in ACPE-provider activities in pharmacy law. The ACPE universal activity number for a pharmacy law activity ends with "03." MM (initial)

d) During the 27-month renewal period indicated, I have completed a minimum of 2 contact hours of CE in activities dealing with medication or patient safety. ACPE-provider activities ending "05" may be used to fulfill this requirement. This requirement may also be fulfilled by completion of nonACPE-provider activities pursuant to 657 subrule 2.12(1)(a). ML (initial)

e) If I am a pharmacist engaged in the administration of vaccines pursuant to rule 657—8.33, I have completed a minimum of 1 contact hour of CE dealing with vaccines. _____ (initial) or NLK (Not Applicable)

f) During the 27-month renewal period indicated, I was approved for exemption from CE requirements while continuing formal education in a health-related graduate program. _____ (initial) _____ (approved exemption period)

g) I have completed and submitted with this application a continuing professional development (CPD) portfolio pursuant to rule 657—2.17. _____ (initial)

If you have not completed a total of at least 30 contact hours of CE (including a minimum of 15 hours in ACPE-provider activities dealing with drug therapy, 2 hours in ACPE-provider activities in pharmacy law, and 2 hours in activities dealing with patient or medication safety), OR have not met the CE requirements of another state in which you currently reside and are licensed to practice pharmacy, OR have not been granted an exemption from CE requirements, OR have not completed and submitted a continuing professional development portfolio pursuant to rule 657—2.17, you will be issued an INACTIVE license.

AN INACTIVE LICENSEE MAY NOT PRACTICE PHARMACY IN IOWA.

CURRENT PRACTICE/EMPLOYMENT:

12 Principal place of employment.

Business Name Unemployed
Address _____
City _____ State _____ Zip _____

(a) Nature of pharmacy practice (if any) at this location (check one):

Community Mail Order/Managed Care Hospital
 Long-Term Care Home Health Care Nuclear
 Correctional Facility Wholesale/Distribution Manufacture
 Education Government Other (specify) N/A

(b) If primary employment is not in pharmacy or related practice, please indicate employment status (check one):

Unemployed but Not Retired Retired Engaged in Other Practice (specify) _____

13 Are you currently practicing pharmacy in Iowa? yes no If yes, complete (a), (b), and (c) below.

(a) Iowa Pharmacy License Number of primary practice site: _____

(b) Nature of pharmacy employment in Iowa (check all that apply):

Proprietor/Sole Owner Partner Employee Manager (PIC, Director, Supervisor)
 Employee Pharmacist (Staff, Clinical) Retired Pharmacist, Occasional Relief Work (Approx. hrs/year) _____

(c) Hours worked per week in pharmacy in Iowa. (Estimate the average number of hours spent each week in each of these practice settings. The sum of the hours should equal the total hours you typically work each week in pharmacy in Iowa.)

Independent Community Pharmacy Chain Pharmacy Long-Term Care Pharmacy
 Mail Order/Managed Care Pharmacy Hospital Pharmacy Home Health Care Pharmacy
 Industry (Wholesale, Manufacture, etc) Nuclear Pharmacy
 Correctional Facility Pharmacy Other Phcy-related (Education, Government, Association, etc)

REMIT TO: IOWA BOARD OF PHARMACY
400 S.W. EIGHTH STREET, SUITE E
DES MOINES, IA 50309-4688
PHONE: (515) 281-5944

Information provided on this application may be disclosed pursuant to 657 IAC Chapter 14.

I hereby swear under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for revocation or other disciplinary sanctions against my license. I also understand that if my license is not renewed to active status prior to expiration, it is illegal to continue to practice pharmacy in Iowa.

SIGN HERE 

[Signature]
Signature of Licensed Pharmacist

9/28/15
Date

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO APPLICANT

Privacy Act Notice: Disclosure of your Social Security number on this license application is required by 42 U.S.C. §666(a)(13) and Iowa Code §§ 252J.8(1), 261.126(1), and 272D.8(1) (2009). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18 (2009).

After filling out form, print, sign, and mail to: Iowa Board of Pharmacy
400 SW 8th Street, Suite E, Des Moines, Iowa 50309-4688. Deadline for inclusion on
Board's agenda is three weeks prior to Board meeting.

Case No. or State ID No.

Rec'd:

IOWA BOARD OF PHARMACY
Petition for Waiver Variance
(check the appropriate box)

PLEASE PRINT OR TYPE ALL INFORMATION IN INK

A waiver excuses the petitioner from the requirements of a rule in its entirety or from a part of a rule; a variance does not. Instead, a variance is a modification to the requirements of a rule or a part of a rule. Example: A rule requires the fencing of certain property and further requires that the fence be at least 6 feet in height. A waiver of that rule would excuse the petitioner from the requirement for fencing the property. A variance would require the property be fenced but would allow the petitioner to maintain the current fencing configuration of 5 feet in height (perhaps the fence was constructed prior to the height requirement). When replacement of the current fence becomes necessary as a consequence of normal wear and tear, the variance would terminate and the petitioner would be required to comply with the 6-foot height requirement.

Note: Statutory requirements that have been repeated in administrative rules are not subject to consideration for a waiver or variance.

Is this petition an initial request or is it a request for renewal? Initial Request Request for Renewal
If a request for renewal, explain below why the renewal is necessary.

Petitioner Information (include licensee/registrant name and name of contact person, i.e. pharmacist in charge)

Name: **Matthew John Kolb**
Phone No.: XXXXXXXXXX
Pharmacist license# **21184**

(include area code)

Address: **6555 W 59th St** State: **IL** Zip Code: **60638**
City: **Chicago**

Petition Information

1. Chapter Number and Title.

CH 2, P. 4

2. Rule Number(s) and Title(s).

2.11(1) LATE PAYMENT PENALTY

3. Describe in your own words the essence of each Rule Number(s) and Title(s) that pertains to this petition.

I would like to be exempted from the late fee on my license.

4. Describe the specific nature and scope of your petition. In your description, include the anticipated time period (beginning and ending) for which the petition would apply. A waiver or variance may not be requested or granted on a permanent basis; the petition must identify an end date.

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This is a onetime request specific to only the renewal of my license occurring in 2015.

5. Describe the relevant facts and reasons that, in your opinion, justify and provide "clear and convincing evidence" as to why this petition merits consideration for waiver or variance. In your description, explain why the rule(s) poses an undue hardship. If there is a public health, safety and welfare issue associated with this rule(s), or if this rule(s) addresses security or confidentiality issues, also explain how equal protection will be maintained if this petition were granted.

I obtained my Iowa pharmacist license in 2010 as a requirement for a position with Rx Remote Solutions. I ceased working there in May of 2014 and took a new job at Midwest Benefits Pharmacy. I was not using my Iowa license at Midwest Benefit Pharmacy. But unfortunately, I was laid off from that position in June of 2015 because the pharmacy closed (in the same month that my Iowa license expired).

It came as a surprise and I was very distraught and worried about my financial situation because the job market around Chicago is very poor for pharmacists seeking employment. I had chosen at the time to not renew my Iowa license because of these financial concerns. But now I have found a potential job with Cardinal Health where they are specifically looking for Iowa licenses in order to do remote order entry with them. It is only a part-time position but at least I would be making some money again.

It would be very helpful for me to have my late fee waved because I am still in a difficult situation financially and have yet to find full-time employment after more than 2 months . Thank you very much for hearing my petition and I hope you will be able to help me in this0 situation.

6. Does anyone else (inside or outside state government) possess knowledge relevant to this petition?

Yes No Do not know

If yes, list their names, addresses and phone numbers below.

**Midwest Operating Engineers Human Resources (who can confirm my loss of job):
Kerriann Travis
708-482-7300**

**6150 Joliet Rd
Countryside, IL**

7. Would anyone (inside or outside state government) be adversely affected if this petition were granted?

Yes No Do not know

If yes, list their names, addresses and phone numbers below.

8. Do you know how the Board of Pharmacy has treated similar situations?

Yes No

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If yes, describe below how similar situations were handled.

9. Have you had any past interaction with the Board of Pharmacy that might impact or relate to this petition?

Yes No

If yes, describe below the issue involved and the outcome.

I authorize any person with knowledge of the relevant or important facts relating to this petition to release any pertinent information to the Iowa Board of Pharmacy. I hereby attest to the accuracy and truthfulness of the information contained herein.



Petitioner's Signature



Date



928

70-7257/2719 79
4875466682

9/28/15

Date

Pay to
the order

Iowa Board of Pharmacy

\$

Dollar



Security
Features
Details on
Back.



Renewal of
21184

