NYS-APP-3 #20-127 (3/2023 L)
www.cs.ny.gov

APPLICATION FOR NYS EXAMINATIONS OPEN TO THE PUBLIC

Send Completed Application to:	Mail your Application and Supplement to the agencies where you wish to work. See page 1 on the Supplement for a listing of agencies.

Exam No.	Title
20-127	**Pharmacist**

Last Name | First Name | MI

Mailing Address: No., Street, Apt., or P.O. Box

City or Post Office | State | Zip Code

Email Address

Social Security Number

Home Phone | Day Phone

PERSONAL PRIVACY PROTECTION LAW NOTIFICATION

The information which you are providing on this application is being requested pursuant to Section 50.3 of the New York State Civil Service Law for the principal purpose of determining the eligibility of applicants to participate in the examination(s) for which they have applied. This information will be used in accordance with Section 96(1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e), and (f). Failure to provide this information may result in disapproval of the application. This information will be maintained by the facility where you send your application. For further information, relating only to the Personal Privacy Protection Law, call (518) 457-9375. **For examination information on this examination, call the agency where you send your application.**

EXTRA CREDITS FOR WAR TIME VETERANS

COMPLETE THIS SECTION ONLY IF YOU: Wish to claim War Time Veteran Credits, **AND** have not used **DISABLED** veteran credits for a permanent appointment to a position in New York State or Local Government.

Answering questions in this section means that you are requesting extra credits as either a non-disabled veteran or a disabled veteran. All veterans are encouraged to answer questions in this section of the application to ensure that appropriate points are added to passing examination scores. Veterans who answer "YES" to questions 1, 2, AND 3 may receive tentative credits as a non-disabled veteran; candidates who also answer "YES" to question 4 may receive tentative disabled veteran credits. If you previously used non-disabled veteran credits to obtain a permanent appointment to a position in New York State or Local Government, and subsequent to appointment, were certified as a disabled veteran, you may be eligible to receive additional disabled veteran credits by answering "YES" to BOTH questions 5a **AND** 5b in this section. NOTE: All veterans claiming extra credit will be required to produce eligibility documentation which will be verified at time of interview. Candidates found ineligible for such credit will have the points subtracted from their examination score(s). If it is determined that veteran credits do not increase one's reachability for appointment from an eligible list, the use of veteran credits for such appointment will be waived, and veteran credits can be claimed for future civil service examinations until such time as they are used to receive a permanent appointment as provided by the New York State Constitution.

1. Yes ☐ No ☐ Do you expect to receive or have you already received a discharge which was honorable or release under honorable circumstances from the Armed Forces of the United States; or have you applied to or been approved by the New York State Department of Veterans' Services as a veteran pursuant to the Restoration of Honor Act? The "Armed Forces of the United States" means the Army, Navy, Marine Corps, Air Force and Coast Guard, including all components thereof, and the National Guard when in the service of the United States pursuant to call as provided by Law, on a full-time active duty basis other than active duty for training purposes.

2. Yes ☐ No ☐ Are you now serving, or have you served, on an active duty basis other than active duty for training purposes during one or more of the following **Time of War** periods?

In the Armed Forces:
- Aug. 2, 1990 until the **Persian Gulf hostilities** end
- Feb. 28, 1961 to May 7, 1975
- June 27, 1950 to Jan. 31, 1955
- Dec. 7, 1941 to Dec. 31, 1946

or earned the Armed Forces, Navy, or Marine Corps expeditionary medal for service in:
- **(Panama)** Dec. 20, 1989 to Jan. 31, 1990
- **(Lebanon)** June 1, 1983 to Dec. 1, 1987
- **(Grenada)** Oct. 23, 1983 to Nov. 21, 1983

or in the U.S. Public Health Service:
- June 26, 1950 to July 3, 1952
- July 29, 1945 to Sept. 2, 1945

3. Yes ☐ No ☐ Are you a United States citizen or an alien lawfully admitted for permanent residence?

4. Yes ☐ No ☐ Do you have a service connected disability rated at 10% or more by the U.S. Department of Veterans Affairs? This disability must have been incurred during a Time of War period listed above.

5a. Yes ☐ No ☐ Have you **USED NON-DISABLED** veteran credits for a permanent appointment to a position in New York State or Local Government? If you answered "Yes" to "5a" above, you must answer "5b":

5b. Yes ☐ No ☐ **After** you were permanently appointed using non-disabled veteran credits, were you **subsequently** certified as having a service connected disability rated at 10% or more by the U.S. Department of Veterans Affairs?

New York State Residency Requirement for Extra Credits as a War Time Veteran or Disabled Veteran: You will be required to provide proof of current New York State residency at time of appointment.

ELIGIBILITY FOR EMPLOYMENT

You must be legally eligible to work in the United States at time of appointment and throughout your employment with New York State. If appointed, you must produce documents that establish your identity and eligibility to work in the United States, as required by the Federal Immigration Reform and Control Act of 1986, and the Immigration and Nationality Act.

I affirm under penalties of perjury that all statements made on this application (including any attached papers) are true. I understand that all statements made by me in connection with this application are subject to investigation and verification and that a material misstatement or fraud may disqualify me from appointment and/or lead to revocation of my appointment.

X _____ _____

Signature of Applicant | Date | Please print any other last name by which you are or have been known.

It is the policy of the State of New York to provide for and promote equal opportunity employment, compensation, and other terms and conditions of employment without unlawful discrimination on the basis of age, race, color, religion, disability, national origin, gender, sexual orientation, veteran or military service member status, marital status, domestic violence victim status, genetic predisposition or carrier status, arrest and/or criminal conviction record, or any other category protected by law, unless based upon a bona fide occupational qualification or other exception.

It is the policy of New York State Department of Civil Service to provide qualified persons with disabilities equal opportunity to participate in and receive the benefits, services, programs and activities of the Department, and to provide such persons reasonable accommodations and reasonable modifications as are necessary to provide such equal opportunity, including accommodations in the examination process. Further, it is the policy of the Department to provide reasonable accommodations for religious observance.

SOCIAL SECURITY NUMBER

There is no application fee for this examination.

CONTINUOUS RECRUITMENT EXAMINATION NO. 20-127
EDUCATION, TRAINING, AND EXPERIENCE SUPPLEMENT FOR PHARMACIST

This is an EDUCATION, TRAINING, AND EXPERIENCE EXAMINATION. Your rating will be based solely upon a review of your responses to this supplement. All information provided is subject to verification. THIS IS YOUR TEST

INSTRUCTIONS

1. **Please print clearly in ink.**

2. Answer all questions on this supplement and application form NYS-APP-3 #20-127 completely and accurately. **Incomplete information may result in a lower score or disqualification. Retain a copy of the completed supplement for your records.**

3. This supplement will be the only basis for rating your education, training, and experience. You may submit your resume in addition to this application, but you must still complete all parts of the application without reference to the resume.

4. Your degree and/or college credits must have been awarded from a regionally accredited college or university or one recognized by the New York State Education Department as following acceptable educational practices. If your degree and/or college credit was awarded by an educational institution outside the United States and its territories, you must provide independent verification of equivalency. A list of acceptable companies who provide this service or this information can be found on the Internet at: http://www.cs.ny.gov/jobseeker/degrees.cfm

5. **You must mail a completed NYS-APP-3 #20-127 and SUPP #20-127 to one or more of the following:**

NYS Department of Corrections and Community Supervision
Office of Human Resources
1220 Washington Avenue
State Office Building Campus, Building #2
Albany, New York 12226-2050

NYS Office of Mental Health
Decentralized List Unit
44 Holland Avenue
Albany, NY 12229

New York State Office for People With Developmental Disabilities
Main Office Personnel
44 Holland Avenue
Albany, New York 12229

6. Additional unsolicited information will not be accepted after receipt of your application.

7. Retest Policy- You may reapply for this exam every twelve months. A new application/supplemental questionnaire must be submitted.

8. Appropriate part-time and volunteer experience, which can be verified, will be accepted on a prorated basis.

SOCIAL SECURITY NUMBER

CONTINUOUS RECRUITMENT EXAMINATION NO. 20-127
EDUCATION, TRAINING AND EXPERIENCE SUPPLEMENT FOR PHARMACIST

There is no application fee for this examination.

I. NYS LICENSE OR CERTIFICATION

You must possess a license and current registration to practice pharmacy in New York State.
To qualify for this examination, you must provide complete information. **Failure to provide complete information below will result in disqualification.**

License Number:	Current Registration: MO. YR. MO. YR.
Date First Issued:	FROM TO

II. ACADEMIC RECORD

Indicate any degrees received or expected to be received. Please specify the type of degree. Failure to provide complete information below may result in a lower score.

College, University, Professional or Technical Schools	Semester Credits Received	Quarter Hours Received	Type of Degree Received	Major Subject or Type of Course	Did You Graduate	Degree Expected
Name					☐ Yes ☐ No	MO. YR.
Address (City, State)						
Name					☐ Yes ☐ No	MO. YR.
Address (City, State)						

College, University, Professional or Technical Schools	Semester Credits Received	Quarter Hours Received	Type of Degree Received	Major Subject or Type of Course	Did You Graduate	Degree Expected
Name					☐ Yes ☐ No	MO. YR.
Address (City, State)						
Name					☐ Yes ☐ No	MO. YR.
Address (City, State)						

College, University, Professional or Technical Schools	Semester Credits Received	Quarter Hours Received	Type of Degree Received	Major Subject or Type of Course	Did You Graduate	Degree Expected
Name					☐ Yes ☐ No	MO. YR.
Address (City, State)						
Name					☐ Yes ☐ No	MO. YR.
Address (City, State)						

SOCIAL SECURITY NUMBER

CONTINUOUS RECRUITMENT EXAMINATION NO. 20-127
EDUCATION, TRAINING AND EXPERIENCE SUPPLEMENT FOR PHARMACIST

There is no application fee for this examination.

III. TRAINING

A. Indicate any pharmacy certification(s) obtained. Please fill out the chart below and attach verification of the certification to your application. Failure to provide complete information below may result in a lower score:

☐ **Certification from Board of Pharmacy Specialties**
☐ **Certification from Commission for Certification in Geriatric Pharmacy**

Certification Number:	Type of Certification:	Current Certification: MO. YR. MO. YR. FROM TO
Date First Issued:		

☐ **Certification from Board of Pharmacy Specialties**
☐ **Certification from Commission for Certification in Geriatric Pharmacy**

Certification Number:	Type of Certification:	Current Certification: MO. YR. MO. YR. FROM TO
Date First Issued:		

B. Indicate experience gained during a post-degree clinical residency program. Failure to provide complete information below may result in a lower score.

☐ **1-year Post Graduate Clinical Residency** ☐ **2-year Post Graduate Clinical Residency**

LENGTH OF EMPLOYMENT MO. YR. MO. YR. FROM TO	FIRM NAME	ADDRESS	CITY AND STATE
TYPE OF BUSINESS	DUTIES:		
YOUR EXACT TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
No. of hours worked per week (exclusive of overtime):			

(continued on next page)

SOCIAL SECURITY NUMBER

CONTINUOUS RECRUITMENT EXAMINATION NO. 20-127
EDUCATION, TRAINING AND EXPERIENCE SUPPLEMENT FOR PHARMACIST

There is no application fee for this examination.

III. TRAINING (continued)

☐ **1-year Post Graduate Clinical Residency** ☐ **2-year Post Graduate Clinical Residency**

LENGTH OF EMPLOYMENT MO. YR. MO. YR. FROM TO	FIRM NAME	ADDRESS	CITY AND STATE
	DUTIES:		
TYPE OF BUSINESS			
YOUR EXACT TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
No. of hours worked per week (exclusive of overtime):			

IV. DESCRIBE YOUR EXPERIENCE

Beginning with your most recent experience, list all employment, military service, or volunteer experience as a Registered Pharmacist and/or in the pharmacy industry (excluding pharmaceutical sales). We cannot interpret omissions or vagueness in your favor. You are responsible for an accurate and clear description of your experience. Do not send your resume. Under **DUTIES** describe the nature of the work which you personally performed including the estimated percentage of time spent on each type of activity. If you supervised, state how many people and the nature of such supervision.

LENGTH OF EMPLOYMENT MO. YR. MO. YR. FROM TO	FIRM NAME	ADDRESS	CITY AND STATE
	DUTIES:		
TYPE OF BUSINESS			
YOUR EXACT TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
No. of hours worked per week (exclusive of overtime):			

(continued on next page)

SOCIAL SECURITY NUMBER

There is no application fee for this examination.

CONTINUOUS RECRUITMENT EXAMINATION NO. 20-127
EDUCATION, TRAINING AND EXPERIENCE SUPPLEMENT FOR PHARMACIST

IV. DESCRIBE YOUR EXPERIENCE (continued)

LENGTH OF EMPLOYMENT MO. YR. MO. YR. FROM TO	FIRM NAME	ADDRESS	CITY AND STATE
TYPE OF BUSINESS	DUTIES:		
YOUR EXACT TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
No. of hours worked per week (exclusive of overtime):			

LENGTH OF EMPLOYMENT MO. YR. MO. YR. FROM TO	FIRM NAME	ADDRESS	CITY AND STATE
TYPE OF BUSINESS	DUTIES:		
YOUR EXACT TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
No. of hours worked per week (exclusive of overtime):			

LENGTH OF EMPLOYMENT MO. YR. MO. YR. FROM TO	FIRM NAME	ADDRESS	CITY AND STATE
TYPE OF BUSINESS	DUTIES:		
YOUR EXACT TITLE			
NAME OF YOUR SUPERVISOR			
SUPERVISOR'S TITLE			
No. of hours worked per week (exclusive of overtime):			

If you need additional space, please continue on a separate 8 ½ x 11 sheet of paper and attach at the end of the application.

SOCIAL SECURITY NUMBER

There is no application fee for this examination.

CONTINUOUS RECRUITMENT EXAMINATION NO. 20-127
EDUCATION, TRAINING AND EXPERIENCE SUPPLEMENT FOR PHARMACIST

ADDITIONAL EXAMINATION CREDITS PURSUANT TO CIVIL SERVICE LAW SECTION 85-a

If you are a child or sibling of a firefighter, police officer, emergency medical technician, or paramedic who was killed in the line of duty in the service of New York State, you may be entitled for additional examination credits pursuant to Civil Service Law Section 85-a. For further information, please contact the Department of Civil Service at (518) 474-9721.

ADDITIONAL QUESTIONS

If you answer YES to any of these questions, please provide an explanation in the REMARKS section provided below:

1. Yes ☐ No ☐ Were you ever discharged from any employment except for lack of work, funds, disability or medical condition?

2. Yes ☐ No ☐ Did you ever resign from any employment rather than face a dismissal?

Remarks:

USE ADDITIONAL SHEETS IF NECESSARY TO COMPLETE INFORMATION

THIS AFFIRMATION MUST BE COMPLETED

I affirm under penalties of perjury that all statements made on this supplemental questionnaire (including any attached papers) are true and accurate. I understand that all statements made by me in connection with this supplemental questionnaire are subject to investigation and verification and that a material misstatement or fraud may disqualify me from appointment and/or lead to revocation of my appointment. I also affirm that I have completed this form independently and without assistance from other candidates or employees of the NYS Office of Corrections and Community Supervision, NYS Office for People with Developmental Disabilities, or NYS Office of Mental Health.

Signature: _____

Date: _____