Form III – 11/2012

KENTUCKY BOARD OF PHARMACY

Internship Report

Note: Preceptor Affidavit MUST be received within 10 days of starting Internship to be reported on this form.

Name _____ Intern No. _____
(Last) (First)

Address_____

I am currently enrolled at _____ college/university under the immediate

supervision of _____at_____.
(Pharmacist Preceptor) (Name of Pharmacy)

Phone Number _____ _____
(Signature)

MONTH	WEEK ENDING DATE	YEAR	NUMBER OF HOURS PER WEEK	*		MONTH	WEEK ENDING DATE	YEAR	NUMBER OF HOURS PER WEEK	*

* Check (√) each week you were ACTIVELY ATTENDING CLASS in a college of pharmacy or indicate (R) if on ROTATIONS.

I hereby certify that this report is a correct statement of fact. The above information was taken from the records of the above named pharmacy and is available for examination by the Kentucky Board of Pharmacy.

_____ _____
(Date) (Signature of Preceptor)

A separate Form III for each preceptor must be submitted and received in the Board office by graduation. Mail to:

Kentucky Board of Pharmacy
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort, KY 40601

(For Office Use)

_____ Hours Internship Credited _____Total Hours Internship Credited

Date _____ Approved _____

FOR INTERNSHIP OUTSIDE OF KENTUCKY

The Pharmacist Preceptor and Pharmacy named in the preceding report are currently in good standing with this Board.

Date _____ By _____

Title _____

Board of Pharmacy _____

(Seal)

(The above must be completed by an official of the Board of Pharmacy in the state where internship was obtained.)