State of Alaska
Department of Commerce, Community, and Economic Development
Division of Corporations, Business and Professional Licensing
Board of Pharmacy
P.O. Box 110806
Juneau, Alaska 99811-0806
(907) 465-2589
E-mail: license@commerce.state.ak.us

ALASKA STATE BOARD OF PHARMACY
INTERN AFFIDAVIT OF EXPERIENCE

(Form must be submitted within 30 days of completion or termination of an internship.)

Pharmacist Intern: Complete only the top portion of this form. The supervising pharmacist will complete the remainder of the form and return the completed form to the Alaska Board of Pharmacy where your intern hours will be recorded.

_____ _____
Intern Pharmacist Name Signature

_____ _____
License Number Address

_____ _____
Dates of Internship

Supervising Pharmacist:
Complete form in full and return to Alaska Board of Pharmacy within 30 days of completion or termination of internship.

I, _____, am a licensed registered
Supervising Pharmacist

pharmacist holding certificate of licensure number _____, in the State of _____. I

certify that _____ was in my employ and under my direct supervision,
Name of Intern

compounding and selling drugs and filling prescriptions for medical practitioners for a period of _____

years and _____ months in a pharmacy at _____.
City State Zip

1. Has the intern been permitted to make the sale of poisons, dispense and label them under supervision and cause the name to be recorded in the poison register? _____ To what extent or approximate number of times?
   _____

2. Has the intern been permitted to dispense and label Class V controlled substances and cause the same to be recorded in the exempt narcotic register? _____ Number of times? _____

3. Has the intern made out Class II order forms? _____

4. Has the intern made out a controlled substances inventory? _____

5. Has the intern filled and properly labeled controlled prescriptions under your supervision? _____

6. Indicate approximate number of prescriptions the intern has filled during his/her employment or internship. _____

7. Name current pharmaceutical journals which have been made available to the intern and indicate if he/she has covered them. _____

_____

_____

8. Were the hours completed in conjunction with educational requirements? ☐ Yes ☐ No If yes, how many? ____

Page 3 of this form contains a schedule to be completed by the supervising Registered Pharmacist. Please do not use pencil when completing this form. Enter the exact number of hours completed by the Intern Pharmacist for each day that he/she was under your supervision.

By my signature below, I attest that my replies to the foregoing questions and all statements given herein are true and that to the best of my knowledge that experience thus gained by the intern has been predominantly related to the practice of pharmacy as required by law.

_____
Signature of Registered Pharmacist Supervisor

_____
Printed Name

_____
Store Name

_____
Street Address

_____
City State Zip

_____
Telephone No.

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20_____.

Notary Public for the State of _____

Residing at _____

NOTARY SEAL

_____
Notary Signature

My Commission Expires: _____

Intern Pharmacist _____ **Intern License No.** _____

Year 20_____ Show exact hours and not "x's" **Year 20_____Show exact hours and not x's** **Year 20_____ Show exact hours and not x's**

Day	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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TOTAL HOURS	