



CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF PHARMACY

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AFFIDAVIT OF INTERN EXPERIENCE

If you completed internship hours while employed in a pharmacy business, arrange for your supervising Pharmacist to complete this form.

To be completed by the Applicant and submitted to the supervising Pharmacist:

Name of Applicant: _____

To be completed by the supervising Pharmacist:

1. This is to certify that I am a registered pharmacist in good standing with the Board of Pharmacy, license number _____. I am employed at _____, Pharmacy permit number _____.
2. I further certify that _____ has obtained the following hours of professionally oriented experience in the practice of Pharmacy, under my supervision at the above pharmacy:
3. Enter dates of period(s) during which hours were accrued.

START DATE	END DATE	HOURS
TOTAL HOURS		

Note: Foreign pharmacy graduates must earn the above hours after the date of certification by FPGE.

4. Assess the applicant's professional development in nine areas of Pharmacy Practice as demonstrated at the end of the experience period under your supervision. Use the performance criteria in A through E. The purpose of this evaluation is to alert the intern to weaknesses or any problem areas. If any of these questions does not apply, refer to *Intern Performance Evaluation Comment Sheet*.

Performance Criteria

- A - Intern is able to perform this activity very effectively without supervision. Intern is fully prepared to assume this responsibility in practice.
- B - Intern requires only occasional supervision to perform this activity effectively.
- C - Intern is slow and/or requires frequent supervision to perform this activity. Intern needs additional experience to assume this responsibility in practice.
- D - Intern makes significant mistakes on a regular basis, but may demonstrate an understanding of the concepts.
- E - Intern is either unable to perform or insufficiently prepared to perform this activity.

Areas of Practice

1. Ability to apply knowledge of state and federal pharmacy law in the dispensing of medications:
 A B C D E
2. Ability to apply knowledge of Pharmacy Law in the acquisition (DEA order form) and distribution of controlled substances:
 A B C D E
3. Ability to dispense medications from prescription orders, to include order interpretation, product selection, labeling and packaging:
 A B C D E
4. Ability to dispense (sterile & non-sterile) dosage forms requiring extemporaneous or bulk compounding:
 A B C D E
5. Ability to obtain and utilize patient-related information (i.e. patient profiles, interview, etc.) to insure patient safety and to minimize significant drug interactions and therapeutic incompatibilities:
 A B C D E
6. Ability to effectively consult with patients about their prescription drug therapy:
 A B C D E
7. Ability to perform basic triage functions with patients and to select and counsel patients on appropriate over-the-counter drugs or to refer patients to other health care providers (optional for Hospital Pharmacy Experience Externs/Interns):
 A B C D E
8. Ability to maintain pharmacy records, to include DEA records, prescription files, patient profiles and counseling records:
 A B C D E
9. Ability to communicate with other health care professionals about patient therapy and/or drug information:
 A B C D E

I certify that the applicant's professional assessment AND recorded hours as indicated on this form is accurate, to the best of my ability.

SIGNATURE OF SUPERVISING PHARMACIST: _____

Date: _____

Subscribed and sworn to before me this _____ day of _____ 20____
Witness my hand and seal hereunto attached.

Notary Signature _____
My Commission expires: _____

SEAL

Send this form *directly* to the Board of Pharmacy office at the address above.

