



CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV

AFFIDAVIT OF PRECEPTOR

To be completed by the Applicant and submitted to the preceptor:

Name of Applicant: _____

To be completed by the applicant's preceptor then sent **directly** to the Board.

I hereby certify that I, _____, License # _____, accept the responsibility of a preceptor for the applicant named above. I agree to provide the applicant with the experience outlined in the Board's Practical Experience Program. If I terminate my preceptorship agreement with the applicant, I will notify the Board in writing within 10 calendar days. I also hereby certify that I am a licensed pharmacist and have been practicing for at least two years.

PRECEPTOR SIGNATURE : _____ Date: _____

Subscribed and sworn to before me this _____ day of _____ 2_____
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.