



CANNON BUILDING  
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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

### COLLEGE PRACTICAL EXPERIENCE FORM

**If you completed internship hours while in a School or College of Pharmacy, arrange for your school or college to complete this form.**

To be completed by the Applicant and submitted to the College or School of Pharmacy:

Name of Applicant: \_\_\_\_\_

To be completed by the College or School of Pharmacy

This is to certify that \_\_\_\_\_, a full time student at this Institution has successfully participated in the College's Practical Experience Program. All hours certified below were obtained during the THIRD professional year (FIRST professional year) of the Pharmacy curriculum.

TOTAL HOURS OBTAINED: \_\_\_\_\_

DURING PERIOD: \_\_\_\_\_ THRU \_\_\_\_\_

The current structure of the Practical Experience Program at this institution requires the following minimum experience periods:

\_\_\_\_\_ HOURS in Community Pharmacy Practice

\_\_\_\_\_ HOURS in Hospital Pharmacy Practice

\_\_\_\_\_ HOURS in Clinical Pharmacy Services (e.g., medical rounding, patient chart review, drug therapy assessment, patient interview and education.)

SIGNATURE OF SCHOOL OFFICIAL: \_\_\_\_\_

Title: \_\_\_\_\_ 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.**