CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

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

APPLICATION FOR REGISTRATION OF INTERNSHIP – U.S. SCHOOL

File this application form if you:

- Are in at least the first professional year or have graduated from an accredited School or College of Pharmacy ***in the U.S***.
- Wish to work as a Pharmacist Intern in a Delaware Pharmacy to attain required pre-licensure hours of experience.

If you are a graduate of School or College of Pharmacy *outside the U.S.*, file the *Application for Registration of Internship-Foreign School* form instead.

If you have graduated and wish to take the NAPLEX, you must also submit an *Application for Pharmacist Licensure by Examination or Score Transfer* form.

IDENTIFYING AND CONTACT INFORMATION

1. Name ______________________________ ______________________ ______________
   Last First Middle

2. Other Names Used: ____________________ ____________________ ____________________
   (Include maiden, prior married, alternate spellings)

3. Mailing Address: ____
   Street

   ______________________________ ____________________ ______________
   City State Zip

4. Phone: ____________________ Email: ____

5. Date of Birth (mm/dd/yyyy): ______________

6. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐
   - If yes, enter your SSN: ______________________________
   - If no, you must file a *Request for Exemption from Social Security Number Requirement*.

EDUCATION INFORMATION

7. Name of School or College of Pharmacy: ____

8. Have you graduated? ☐ Yes ☐ No

   Arrange for your school to submit the *Certificate of Class Standing* form.

9. Enter the date you graduated or expect to graduate: ____________________

PRECEPTOR INFORMATION

10. Full Name of Preceptor: ______________ ________________________ License #: ____________________

11. Preceptor Address: ____
Street

______________________________ ______________ ______________
City State Zip

Arrange for your Preceptor to submit the *Affidavit of Preceptor* form. When you complete your internship with this Preceptor, arrange for the Preceptor to submit the *Affidavit of Intern Experience* form. If your preceptor changes, you must submit a new *Affidavit of Preceptor* form within 10 calendar days of the change.

DISCLOSURES

12. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor, or any other criminal offense, including any offense for which you received a pardon, in any jurisdiction? Yes ☐ No ☐ **If yes, arrange for the Board office to receive a criminal background check. See *Instructions for Requesting a Criminal Background Check* at dpr.delaware.gov.**

13. Have you ever been the recipient of an administrative penalty regarding your practice of pharmacy, including but not limited to fines, formal reprimands, license suspension or revocation (except for non-payment of fees), probationary limitations, or been a party to a consent agreement containing conditions placed by a Board on your professional conduct and practice, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, provide documentation of the regulatory Board action**.

14. Do you have any impairment related to drugs, or alcohol, or mental competence that would limit your ability to act as a pharmacist in a manner consistent with the safety of the public? Yes ☐ No ☐

Enclose non-refundable processing fee. See Fee Schedule at dpr.delaware.gov.

To assure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within six months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is complete, please allow 4-8 weeks to receive your registration.

AFFIDAVIT

I do hereby make application to the Board of Pharmacy for license or registration under the provisions of an Act to regulate the practice of Pharmacy in the State of Delaware and solemnly swear and affirm that the answers to the questions set forth in this application are true and correct.

Signature of Applicant: ____________________________________ Date: ______________

Subscribed and sworn to before me this ________________ day of ____________ 2______

Witness my hand and seal hereunto attached.

SEAL

Notary Signature________________________________
My Commission expires: ____________________

APPLICATIONS THAT ARE UNSIGNED, INCOMPLETE, NOT NOTARIZED OR NOT ACCOMPANIED BY THE REQUIRED PROCESSING FEE WILL BE REJECTED.

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

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

CERTIFICATE OF CLASS STANDING

If you received your pharmacy education at a School or College of Pharmacy in the U.S., arrange for your School or College to complete this form.

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

Name of Applicant: ____

To be completed by the Secretary or Dean of the applicant's School or College of Pharmacy:

This is to certify that the applicant named above:

☐ Is a student in good standing entering:
- ☐ First professional year in pharmacy
- ☐ Second professional year in pharmacy
- ☐ Third professional year in pharmacy

☐ Has graduated from ______________________________ with a degree in ________________________ conferred on ______________ (date).

SIGNATURE OF SECRETARY OR DEAN: ____

Date: ________________

SEAL

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

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

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.