Form IV – 11/2012

KENTUCKY BOARD OF PHARMACY

Academic Experience Affidavit

(Please Print)

Pharmacy Intern: ____ Pharmacy Intern Number: _____________

Mailing Address: ____

I hereby certify that the above named pharmacy intern has successfully completed the Academic Experiential Rotations listed below:

____

List pharmacist preceptor, dates, and total hours for each pharmacy practice setting completed:

Pharmacist Preceptor	Inclusive Dates	Hours

Each rotation listed was part of the required academic experience program, offered ____ hours of academic credit, and experience was primarily with patient care activities in pharmacy sites.

I hereby acknowledge that the above pharmacist preceptors are current and in good standing with the Board of Pharmacy of this state.

Degree to be conferred: ☐ Pharm. D. ☐ B.S. Pharmacy

________________________________ (Date)

____ (Signature of College Advisor or Instructor)

________________________________ (Signature of Pharmacy Intern)

____ (Title)

(College of Pharmacy Seal)

____ (College of Pharmacy)

(This form IV must be submitted upon completion of course/program to: Kentucky Board of Pharmacy, State Office Building Annex, Suite 300, 125 Holmes Street, Frankfort, Kentucky, 40601)

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(For Office Use Only)

_________ Hours Internship Credited

_________ Total Hours Internship Credited

Date: ________________________________ Approved: ____