Form II

KENTUCKY BOARD OF PHARMACY

PHARMACIST PRECEPTOR'S AFFIDAVIT

Form II must be submitted within **ten (10) days** from the beginning of internship. Form II must be **resubmitted** within ten (10) days if **change in Pharmacist Preceptor**. Please mail certified, return receipt requested to:

Kentucky Board of Pharmacy
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort, KY 40601
Phone 502-564-7910 Fax 502-696-3806

Pharmacist Intern's Name _____

Pharmacist Intern's ID Number _____

Pharmacist Preceptor's Name _____

Pharmacist Preceptor's License Number _____ State of Licensure _____

Full Name and Address of Pharmacy _____

_____

Pharmacy Permit Number _____

Pharmacist Intern's Starting Date _____

- ❖ I shall maintain personal supervision of the Pharmacist Intern on a one-to-one basis and fully understand that a Pharmacist Intern cannot legally compound or dispense prescriptions except when doing so under the immediate, personal supervision of a certified pharmacist preceptor and may not be left in charge of a pharmacy.
- ❖ I affirm that I will adhere to the requirement of the "Pharmacy Internship Policy" and the requirements of Kentucky law and administrative regulations.

_____ _____

(Date) (Pharmacist Preceptor's Signature)

(It is the Pharmacist Intern's responsibility to submit this form to the Kentucky Board of Pharmacy office within the required time limitation.)

FOR INTERNSHIP OUTSIDE OF KENTUCKY

The Pharmacist Preceptor and Pharmacy named in the preceding report are currently in good standing with this Board.

Date _____ By _____
Title _____
Board of Pharmacy _____

(Seal)

(The above must be completed by an official of the Board of Pharmacy in the state where internship was obtained.)