

FORM 4

PHARMACIST

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234-1000

DEPARTMENT USE ONLY

Sheet total
Previous credit
Total to Date
Requirement complete
Reviewers initials

CERTIFICATION OF AN INTERNSHIP IN PHARMACY

(COPY THIS FORM AS NEEDED AND COMPLETE IT AT THE END OF EACH INTERNSHIP SESSION)

SECTION I: INTERN INFORMATION

1 SOCIAL SECURITY NUMBER

(Leave this blank if you do not have a U.S. Social Security Number)

2 BIRTH DATE

mo. day yr.

3 PRINT YOUR FULL NAME EXACTLY AS IT APPEARS ON YOUR INTERN PERMIT

Check this box if this is a name change and indicate all other names used.

Last
First
Middle

5 Telephone/E-Mail Address

Daytime Phone

Area Code Phone Number

E-Mail Address (Please print clearly)

4 MAILING ADDRESS (You must notify the Department promptly of any address of name changes.)

Line 1
Line 2
Line 3
City
State Zip Code
Country/Province

6 Intern Permit No: Issued mo. / day / yr.

7 College of Pharmacy: Expected Graduation Date:
Check one: B.S. /BPharm degree PharmD
mo. / day / yr.

SECTION II: TO BE COMPLETED BY THE PRECEPTOR PHARMACIST

- (1) Name of Preceptor pharmacist:
(2) Pharmacist license number: (3) Date of licensure: mo. / day / yr.
(4) Name & address of pharmacy:
(5) Registration number of pharmacy: (6) Telephone number:
(7) Exact date internship began: mo. / day / yr. (8) Exact date internship ended: mo. / day / yr. Hours per week
(9) TO MEET THE DEADLINE DATE FOR ADMISSION TO PART III, INDICATE THE EXACT DATE YOU WILL BEGIN AND END THE INTERNSHIP (e.g., 12-15-XX to 01-31-XX or 05-15-XX to 06-30-XX) mo. / day / yr. mo. / day / yr.
(10) Complete and sign the Experience Log on page 3 only if the hours worked each week are different. (Subject to audit - if audited, Pharmacy payroll records must be submitted.)

SECTION III: TO BE SIGNED BY THE INTERN AND PRECEPTOR PHARMACIST
(Note: Intern and Preceptor Pharmacist signatures must be notarized)

1. A valid New York State Pharmacy Intern Permit (required for internships completed in New York only) for the intern named is/was displayed in this pharmacy (If not, attach an explanation).
2. The intern named has been instructed in the practice of pharmacy.
3. The internship has been carried out with the full knowledge and approval of the ownership of the pharmacy.
4. Payroll records or other time records are available for verification of the internship by the Board.
5. The preceptor has practiced as a registered pharmacist for one full year before the beginning date of the internship specified.
6. The preceptor has supervised only one full-time or not more than two part-time interns during the period specified.
7. The pharmacy in which the internship has been completed dispensed more than 5000 prescriptions annually pursuant to section 63.2 (4) of the Education Law for each intern engaged in supervised practice.

We hereby affirm that the above statements are true and accurate.

Signature of intern _____ Date _____

Signature of preceptor _____ Date _____

NOTARY

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above signatories, personally appeared _____, and, _____

and personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by them in the application and all supporting materials are true, complete, and correct.

Notary Public signature _____

Notary ID number _____

Notary Stamp

Expiration date _____ / _____ / _____
Month Day Year

SECTION IV: TO BE COMPLETED ONLY IF YOU ARE SEEKING APPROVAL TO PRACTICE AS AN INTERN PHARMACIST IN A STATE OTHER THAN NEW YORK

Before you begin an internship in another state, confirm your eligibility to do so with that State's Board of Pharmacy.

Internships completed in another state may be accepted as long as the intern meets all requirements to practice pharmacy and is authorized to do so by that State's Board of Pharmacy. This section must be completed and signed by an authorized representative of the state in which the internship will be or has been performed. A separate Form 4 must be submitted for each pharmacy and each preceptor pharmacist.

The Board of Pharmacy of the State of _____ authorizes the above named individual to perform the duties of a pharmacy intern under the supervision of the above named preceptor pharmacist and at the pharmacy listed above. Internship is/was allowed to commence on the following date: _____.

Authorized signature: _____ Date: _____ / _____ / _____
mo. day yr.

Print name: _____

Title: _____

Address: _____

Seal

Telephone: _____ Fax: _____

E-mail: _____

RETURN DIRECTLY TO: _____

New York State Education Department, Office of the Professions, State Board of Pharmacy, 89 Washington Avenue, Albany, New York, 12234-1000.

PHARMACY INTERNSHIP EXPERIENCE LOG FOR THE YEAR _____

TO BE SUBMITTED WITH FORM 4 **ONLY** IF THE HOURS WORKED EACH WEEK ARE DIFFERENT

INSTRUCTIONS

A total of six months consisting of 40-hour credits per 7-day workweek (1040 hours) of supervised pharmacy internship practice is required for admission to Parts II and III of the New York State Licensing Examination Series. Twelve months (2080 hours) is required for graduates of non-accredited schools. Credit for internship may be concurrent with school enrollment only if six or fewer semester hours are being taken by the intern. **Confirmation is required from the college stating the number of credits being taken. On the next page, indicate the number of hours worked each day (do not indicate time such as 8 am – 5 pm).** Total each column and place a grand total in the space provided. This form must be signed and dated by both the preceptor and the intern.

The intern and preceptor signing this form attest under penalty of perjury that the intern hours worked and indicated on page 4 of this form are accurate. False or misleading information may result in disciplinary action being taken against both the intern and preceptor pharmacist.

Intern _____ *Date* _____

Signature _____

Limited (Intern) Permit number _____

Preceptor _____ *Date* _____

Signature _____

License number _____

Pharmacy Intern Experience Log

Intern name _____ Year _____

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
21												
22												
23												
24												
25												
26												
27												
28												
29												
30		X										
31		X		X		X			X		X	
Total												
Credit												

Grand total credit earned for this sheet _____ hours