Pharmacist Form 4

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Department Use Only

Sheet Total

Previous Credit

Total to Date

Requirement Complete

Reviewers Initials

Certification of an Internship in Pharmacy

(A separate Form 4 must be completed at the end of each internship session)

Submit this form ONLY if you are:

- a 6th year student attending an ACPE accredited program leading to a PharmD **AND** want early admission to the compounding exam (Part III); or
- a graduate of a non-accredited (foreign) program.

Do NOT submit this form if you are in your final year of an ACPE accredited program leading to a PharmD and expect to graduate between the Form 4 filing deadline and the date of the compounding exam (Part III).

Graduates of an ACPE-accredited program are automatically deemed eligible for admission to the Part III exam.

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** Month ☐☐ Day ☐☐ Year ☐☐

3 **Print Name Exactly As It Appears on Your Intern Permit**

Last

First

Middle

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

4 **Mailing Address** (You must notify the Department promptly of any address or name changes.)

Line 1

Line 2

Line 3

City

State Zip Code

Country/ Province

5 **Telephone/E-Mail Address**

Daytime phone

☐☐☐ ☐☐☐ ☐☐☐☐

Area Code Phone

E-mail Address (please print clearly)

6 Intern Permit Number: _____ Issued: _____ / _____ / _____
mo. day yr.

7 College of Pharmacy: _____

Check one: ☐ B.S. /BPharm degree ☐ PharmD Expected graduation date: _____ / _____ / _____
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. Registered Pharmacy name: _____ **5.** Registration number : _____

6. Pharmacy address: _____

7. Telephone number: _____

8. Provide the **exact** begin and end date for the internship hours being claimed on this form:

Exact begin date: _____ / _____ / _____ **Exact** end date: _____ / _____ / _____ Hours per week: ☐☐
mo. day yr. mo. day yr.

9. Total number of internship hours worked: _____ (Subject to audit - if audited, pharmacy payroll records must be submitted.)

Section III: To be signed by the Intern and Preceptor Pharmacist (Both signatures must be notarized by a Notary Public)

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. The internship hours accumulated are in addition to the hours required for both introductory and advanced practice rotations of the ACPE pharmacy curriculum.
5. Payroll records or other time records are available for verification of the internship.
6. The preceptor has practiced as a registered pharmacist for one full year before the beginning date of the internship specified.
7. The preceptor has supervised only one full-time or not more than two part-time interns during the period specified.
8. The pharmacy in which the internship has been completed dispensed more than 5,000 prescriptions annually pursuant to section 63.2 (4) of the Education Law for each intern engaged in supervised practice.

The intern and preceptor signing this form attest under penalty of perjury that the intern hours worked and indicated on this form (Section II, Item 9) are true and accurate. False or misleading information may result in disciplinary action being taken against both the intern and preceptor pharmacist. We hereby affirm that the above statements are true and accurate.

Signature of Intern: _____ Date: _____ / _____ / _____
mo. day yr.

Signature of Preceptor: _____ Date: _____ / _____ / _____
mo. day yr.

Notary

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the above signatores, 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 all supporting materials are true, complete and correct.

Notary Public signature _____

Notary ID number _____

Expiration date _____ / _____ / _____
mo. day yr.

Notary Stamp

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, Division of Professional Licensing Services, Pharmacy Unit, 89 Washington Avenue, Albany, New York, 12234-1000