

KENTUCKY BOARD OF PHARMACY

Note: Preceptor Affidavit MUST be received within 10 days of starting Internship to be reported on this form.

Internship Report

Name Doe John Intern No. I0000
(Last) (First)

Address 1 Example Ave Frankfort, KY 40601

I shall resume my pharmacy education at College of Pharmacy college/university
 on Aug. 20, 2011 and hereby apply for internship credit as outlined below.

under the immediate supervision of My Preceptor's Name on file
(Pharmacist Preceptor)

at KY Board of Pharmacy 2 Example Ave Frankfort, KY 40601
(Name and Address of Pharmacy)

Phone Number 502-564-7910

John Doe
(Signature)

MONTH	WEEK ENDING DATE	YEAR	NUMBER OF HOURS PER WEEK	*	MONTH	WEEK ENDING DATE	YEAR	NUMBER OF HOURS PER WEEK	*
Oct	7	2011	20	✓	Jan	6	2012	40	
Oct	14	2011	15	✓	Jan	13	2012	32	
Oct	21	2011	20	✓	Jan	27	2012	7	R
Oct	28	2011	16	✓	Feb	3	2012	6	R
Nov	4	2011	20	✓	Feb	10	2012	8	R
Nov	11	2011	18	✓	Feb	17	2012	4	R
Nov	18	2011	14	✓	Feb	24	2012	16	✓
Nov	25	2011	7	✓	Mar	3	2012	20	✓
Dec	2	2011	12	✓	Mar	10	2012	17	✓
Dec	9	2011	15	✓	Mar	17	2012	19	✓
Dec	16	2011	35		Mar	31	2012	15	✓
Dec	23	2011	37						
Dec	30	2011	36						

* Check (✓) each week you were ACTIVELY ATTENDING CLASS in a college of pharmacy or indicate (R) if on ROTATIONS.

I hereby certify that this report is a correct statement of fact. The above information was taken from the records of the above named pharmacy and is available for examination by the Kentucky Board of Pharmacy.

April 15, 2012
(Date)

My Preceptor's Name
(Signature of Preceptor)

A separate Form III for each preceptor must be submitted and received in the Board office in duplicate by October 1 of each year for all internship experience obtained the preceding twelve months. Mail to:

Kentucky Board of Pharmacy
 State Office Building Annex, Suite 300
 125 Holmes Street
 Frankfort, KY 40601

(For Office Use)

_____ Hours Internship Credited

_____ Total Hours Internship Credited

Date _____

Approved _____