FLORIDA BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN C04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

Please type or print legibly

INTERN AFFIDAVIT REPORT

Name of Intern _____ Intern Number _____
Address _____
Street City State Zip

Have you submitted an application for the Florida Pharmacist Licensure exam? YES _____ NO _____
If so, please indicate exam date: Month _____ Year _____

I hereby apply for internship credit as outlined below worked under the supervision of:

Pharmacist's Name _____ License Number _____

Name of Pharmacy _____ Permit Number _____

Address _____
Street City State Zip

Intern's Signature _____

Date _____

Week Beginning			Week Ending			Total Hours Per Week
Mo	Day	Year	Mo	Day	Year	

Week Beginning			Week Ending			Total Hours Per Week
Mo	Day	Year	Mo	Day	Year	

I hereby certify this report is a correct statement of fact. The above information was taken from the records of the above named pharmacy and are available for inspection by the Board of Pharmacy. I also certify these hours were completed outside of the hours required by the College of Pharmacy.

Preceptor/Supervisor's Signature _____ Date _____

Name of Pharmacy _____ Permit Number _____

Address _____

Street City State Zip

Phone:_____

DH-MQA 101, 10/13
Rule 64B16-26.203, F.A.C.