

Complete forms must be sent directly from the verifying agency to the board office at MQA.Pharmacy@FLHealth.gov, or mailed to:

Board of Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258



Board of Pharmacy

Pharmacy Intern Affirmation Form

Part I: To be completed by applicant

Applicant Name: _____
Last First Middle

Street Address: _____

City: _____ State: _____ ZIP: _____

Part II: To be completed by College of Pharmacy Dean

Name of School/College of Pharmacy: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

This is to certify that the above-named Pharmacy Intern applicant is entered into the professional curriculum of the above-named school as of _____; and is a graduate of said professional curriculum as of _____.
MM/DD/YYYY MM/DD/YYYY

Dean Name: _____

Dean Signature: _____

Date: _____
MM/DD/YYYY

(SCHOOL SEAL)