

Complete forms must be sent directly from the verifying agency to the board office at [info@floridaspharmacy.gov](mailto:info@floridaspharmacy.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)