**Complete forms must be mailed 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
# Internship or Work Experience – Form B

## Part I: Applicant Information

Applicant Name: _____

Intern/Pharmacist License #: _____ Telephone Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Have you submitted an application for the Florida Pharmacist Examination? ☐ Yes ☐ No

Date of application: _____
MM/DD/YYYY

**I hereby apply for internship or work experience credit as outlined below under supervision of**:

## Part II: Pharmacy Information

Supervising Pharmacist Name: _____ License #: _____

Pharmacy Name: _____ Permit #: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: _____ Dates of Experience: From: _____ To: _____
MM/DD/YYYY MM/DD/YYYY

Average # of Hours Per Week: _____ Total Hours of Experience: _____

**(No more than 50 hours per week if you are a student and no more than 60 after graduation are permitted.)**

Applicant Signature _____ Date _____
MM/DD/YYYY

I state the information provided on this report are true and correct. This information was provided by the records of the above-named pharmacy which are available for inspection by the Board of Pharmacy.

Preceptor/Supervisor Signature _____ Date _____
MM/DD/YYYY

**Check to ensure that all fields have been filled in.**