



NORTH DAKOTA STATE BOARD OF PHARMACY

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MUST BE LEGIBLY WRITTEN

AFFIDAVIT OF LICENSED PHARMACISTS/PRECEPTORS

_____ was under the following Licensed Pharmacist/Preceptors
(Name of Licensed Intern Pharmacist) (Intern No.) for the Experiential Program Rotations approved by the
North Dakota State Board of Pharmacy.

if on rotation you:
Dispense Compound

1	Community Advanced Practice	200	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____ Dates							
2	Hospital Advanced Practice	200	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____ Dates							
3	Adult Medicine	200	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____ Dates							
4	Rural Community Practice	200	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____ Dates							
5	_____ (Indicate Elective Rotation)	200	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____ Dates							
6	_____ (Indicate Elective Rotation)	200	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____ Dates							
7	_____ (Indicate Elective Rotation)	200	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____ Dates							
8	_____ (Indicate Elective Rotation)	200	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____ Dates							

Total Hours = 1600

THE ABOVE TOTAL HOURS ARE ACCEPTED AND APPROVED BY THE NORTH DAKOTA STATE BOARD OF PHARMACY.

AFFIDAVIT FROM THE DEAN OF THE COLLEGE OF PHARMACY

This is to certify _____ has completed 1600 hours of
Full Name of Licensed Intern Intern License Number
Experiential Program as required by the North Dakota State Board of Pharmacy Practice Act Laws/Rules and has graduated from
North Dakota State University College of Pharmacy, _____ year curriculum on _____
Graduation Date
with a _____ degree.

Dean

Subscribed and sworn to before me this _____ day of _____ A.D. _____

Notary Public

PROGRESS REPORT OF LICENSED INTERN PHARMACIST

Progress Report to be completed by Licensed Intern Pharmacist after completion of each experiential rotation.

1. COMMUNITY ADVANCED PRACTICE ROTATION:

- a. Briefly describe this experiential rotation: _____

- b. Objectives/goals of rotation : SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____

2. HOSPITAL ADVANCED PRACTICE ROTATION:

- a. Briefly describe this experiential rotation: _____

- b. Objectives/goals of rotation : SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____

3. ADULT MEDICINE EXPERIENTIAL ROTATION:

- a. Briefly describe this experiential rotation: _____

- b. Objectives/goals of rotation : SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____

4. RURAL COMMUNITY PRACTICE ROTATION:

- a. Briefly describe this experiential rotation: _____

- b. Objectives/goals of rotation : SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____

5. _____
(Name of elective experiential rotation)

- a. Briefly describe this experiential rotation: _____

- b. Objectives/goals of rotation : SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____

6. _____
(Name of elective experiential rotation)

- a. Briefly describe this experiential rotation: _____

- b. Objectives/goals of rotation : SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____

7. _____
(Name of elective experiential rotation)

- a. Briefly describe this experiential rotation: _____

- b. Objectives/goals of rotation : SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____

8. _____
(Name of elective experiential rotation)

- a. Briefly describe this experiential rotation: _____

- b. Objectives/goals of rotation : SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____

I ATTEST THAT I COMPLETED EXPERIENTIAL ROTATIONS AS SHOWN ON THE ABOVE PROGRESS REPORT FORM UNDER THE DIRECT SUPERVISION OF THE LICENSED PHARMACIST WHO SIGNED ACCORDINGLY ON THE NOTARIZED AFFIDAVIT (opposite side of this form) IN ACCORDANCE WITH THE LAWS AND RULES OF THE NORTH DAKOTA STATE BOARD OF PHARMACY.

Signature of Licensed Intern Pharmacist

Intern Number

Date