



**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

<b>1</b>	Community Advanced Practice	<b>200</b>	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____							
	Dates							
<b>2</b>	Institutional Practice	<b>200</b>	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____							
	Dates							
<b>3</b>	Acute Care/General Medicine	<b>200</b>	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____							
	Dates							
<b>4</b>	Ambulatory Care Practice	<b>200</b>	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____							
	Dates							
<b>5</b>	Rural Practice	<b>200</b>	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____							
	Dates							
<b>6</b>	_____ (Indicate Elective Rotation)	<b>200</b>	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____							
	Dates							
<b>7</b>	_____ (Indicate Elective Rotation)	<b>200</b>	Hours Credit	<input type="checkbox"/>	<input type="checkbox"/>	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
	_____							
	Dates							
<b>8</b>	_____ (Indicate Elective Rotation)	<b>200</b>	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. INSTITUTIONAL PRACTICE ROTATION:

- a. Briefly describe this experiential rotation: \_\_\_\_\_  
\_\_\_\_\_
- b. Objectives/goals of rotation : SATISFACTORY \_\_\_\_\_ UNSATISFACTORY \_\_\_\_\_ NEEDS IMPROVEMENT \_\_\_\_\_

3. ACUTE CARE/GENERAL MEDICINE EXPERIENTIAL ROTATION:

- a. Briefly describe this experiential rotation: \_\_\_\_\_  
\_\_\_\_\_
- b. Objectives/goals of rotation : SATISFACTORY \_\_\_\_\_ UNSATISFACTORY \_\_\_\_\_ NEEDS IMPROVEMENT \_\_\_\_\_

4. AMBULATORY CARE PRACTICE ROTATION:

- a. Briefly describe this experiential rotation: \_\_\_\_\_  
\_\_\_\_\_
- b. Objectives/goals of rotation : SATISFACTORY \_\_\_\_\_ UNSATISFACTORY \_\_\_\_\_ NEEDS IMPROVEMENT \_\_\_\_\_

5. RURAL COMMUNITY PRACTICE 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