NORTH DAKOTA STATE BOARD OF PHARMACY

1838 E Interstate Ave Suite D Bismarck, ND 58503
Phone: 701-877-2404 Fax: 701-877-2405
Email: ndboph2@ndboardpharmacy Website: www.nodakpharmacy.com

MUST BE LEGIBLY WRITTEN

AFFIDAVIT OF LICENSED PHARMACISTS/PRECEPTORS

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

☑ if on rotation you:

			Dispense	Compound				
1	Community Advanced Practice ☐ Check box if rural	200 Hours Credit	☐	☐	_____ Dates	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
2	Hospital Advanced Practice ☐ Check box if rural	200 Hours Credit	☐	☐	_____ Dates	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
3	Inpatient General Medicine Practice ☐ Check box if rural	200 Hours Credit	☐	☐	_____ Dates	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
4	Ambulatory Care Practice ☐ Check box if rural	200 Hours Credit	☐	☐	_____ Dates	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
5	_____ (Indicate Elective Rotation) ☐ Check box if rural	200 Hours Credit	☐	☐	_____ Dates	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
6	_____ (Indicate Elective Rotation) ☐ Check box if rural	200 Hours Credit	☐	☐	_____ Dates	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
7	_____ (Indicate Elective Rotation) ☐ Check box if rural	200 Hours Credit	☐	☐	_____ Dates	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.
8	_____ (Indicate Elective Rotation) ☐ Check box if rural	200 Hours Credit	☐	☐	_____ Dates	_____ Signature of Licensed Pharmacist/Preceptor	_____ State	_____ License No.

Total Hours = 1600

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

AFFIDAVIT FROM THE NDSU SCHOOL 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 School of Pharmacy, on _____ with a PharmD degree.
Graduation Date

_____
NDSU Senior Associate Dean

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

_____
Notary Public

THIS FORM MUST BE RETURNED TO THE BOARD OF PHARMACY AFTER COMPLETION OF ALL Eight (8) EXPERIENTIAL ROTATIONS

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. INPATIENT GENERAL MEDICINE PRACTICE:
   a. Briefly describe this experiential rotation: _____
   _____
   b. Objectives/goals of rotation: SATISFACTORY _____ UNSATISFACTORY _____ NEEDS IMPROVEMENT _____
4. AMBULATORY CARE:
   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 PRECEPTOR 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

THIS FORM MUST BE RETURNED TO THE BOARD OF PHARMACY AFTER COMPLETION OF ALL Eight (8) EXPERIENTIAL ROTATIONS