Substitute forms are not acceptable - This form may be duplicated as needed .

Rhode Island Board of Pharmacy
Room 103, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-2837

PRECEPTOR AFFIDAVIT OF INTERNSHIP HOURS

Applicant Should Complete this Section Only:

I hold a valid Limited License as a pharmacy intern, and the Rhode Island Board of Pharmacy requires that this form be completed by each licensed pharmacist who served as my preceptor.

Intern Full Name (Print or Type)

Previous Names Used

Intern Address

City/State/Zip

***** FOR OFFICE USE *****

Limited License No. _____

Date Issued: _____

Training Period Valid: ☐ Yes ☐ No

Hours Accepted: _____

THIS SECTION TO BE COMPLETED BY PRECEPTOR

I am a licensed pharmacist in the State of _____. I am an owner, manager, department head, or employee at a licensed business or institution. I was the preceptor of the above-listed pharmacy intern, who has satisfactorily completed practical experience under my supervision.

Preceptor Full Name (Print or Type) _____ License Number _____

Previous Names Used

Pharmacy Name _____ License Number _____

Pharmacy Address

City/State/Zip

Intern's Training Period

☐☐ ☐☐ ☐☐ — ☐☐ ☐☐ ☐☐

Month Day Year Month Day Year

Hours Accrued by Intern

Signature of Preceptor _____ Date _____

Notary:

Name of Notary (Print, Type or Stamp) _____ Signature of Notary _____

Affix Seal Here

Notary No/Commission No. _____ Commission Expiration Date (MM/DD/YY) _____