Complete forms must be sent directly from the verifying agency to the board office at info@floridaspharmacy.gov, or mailed to:

Board *of* Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258

Board *of* Pharmacy Intern Hours Certification Report

Applicants enrolled in a College of Pharmacy in the state of Florida, be advised that upon receipt of certification of graduation, the board will verify completion of 2,080 internship hours. For applicants attending out-of-state college or who would like intern hours certified outside the hours required by the College of Pharmacy in Florida, hours must be recorded on this form and submitted to the board. The Florida board accepts a PharmD as completion of the internship requirement for licensure in Florida. Upon receipt of requests to verify hours our office will send the Intern Hours Certification Report to the state of your choice.

Part I: To be completed by applicant

Intern Name: ______________________________

Intern Number: ______________________ Telephone Number: ______________________

Street Address: ______________________________

City: ______________________ State: ______________________ ZIP: ____________

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

Exam Date: ____________
MM/DD/YYYY

I hereby apply for internship credit as outlined below worked under the supervision of:

Pharmacist Name: ______________________ License #: ______________________

Pharmacy Name: ______________________ Permit #: ______________________

Street Address: ______________________________

City: ______________________ State: ______________________ ZIP: ____________

Intern Signature ______________________________ Date ____________
MM/DD/YYYY

Beginning Date (MM/DD/YYYY)	Ending Date (MM/DD/YYYY)	Total Hours Per Week

Beginning Date (MM/DD/YYYY)	Ending Date (MM/DD/YYYY)	Total Hours Per Week

Applicant Name: ____

Part II: To be completed by Preceptor/Supervisor

I state that this report is correct. The above information was taken from the records of this pharmacy which are available for inspection by the Board of Pharmacy. I also state these hours were completed outside the hours required by the College of Pharmacy.

Pharmacy Name: ____ Permit #: ________________________

Street Address: ____

City: ____ State: _____________________________ ZIP: _____________

Phone: _______________________________________

Preceptor/Supervisor Signature: ____ Date: ________________
MM/DD/YYYY