

Progress Report of Internship

South Dakota State Board of Pharmacy - 3701 West 49th Street, Suite 204, Sioux Falls, SD 57106

Phone: 605-362-2737

www.pharmacy.sd.gov

Name: _____ Registration No: _____

Internship Site: _____

Address/City/State/Zip: _____

This report covers: From: _____ To: _____
(mm/dd/yyyy) (mm/dd/yyyy)

Preceptor's Evaluation of Intern

Use the following for evaluation: 1. Highly Satisfactory 2. Satisfactory
3. Needs Improvement 4. Not Applicable this Period

Personal Qualities

Ability to meet people _____
Ability to cooperate and work with others _____
Ability to comprehend instructions _____
Ability to receive criticism _____
Ability to communicate with and instruct others _____
Attitude toward customers _____
Attitude toward preceptor and pharmacists _____
Attitude toward other employees _____
Attitude toward other health professionals _____
Personal self confidence _____
Personal self discipline _____
Personal hygiene _____
Interest in profession _____
Application of professional knowledge _____

Pharmacy Experience Competencies

Considering the goals and objectives of the internship experience (ARSD 20:51:02:01.01), rate the time spent during this experience in developing competence in the following areas:

1. Receiving and interpreting prescriptions or medication orders _____
2. Compounding prescriptions or medication orders _____
3. Dispensing prescriptions or medication orders _____
4. Reviewing patient medication orders _____
5. Communicating with patients and consulting with other health professionals; and _____
6. Managing a pharmacy _____

Certificates Verifying Experience of Registered Intern

I have complied with the provisions of the South Dakota Board of Pharmacy Regulations (ARSD 20:51:02) and the instructions and rules of internship furnished me at the time of application, and consider the above progress report of internship training to be a correct statement of fact.

Intern Signature

Date

I certify that I am a registered pharmacist, and the same person who by endorsement of application, agreed to supervise the internship training of person listed above. I have completed the preceptor's evaluation of internship, and declare and affirm under the penalties of perjury that this information has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

*I certify that _____ hours were earned for the reporting period _____ to _____
(beginning date) (ending date)*

Preceptor Signature (must be the same as on Affidavit)

Date

RPh Cert No.

State

INTERN HOURS SUBMITTED TO THE SOUTH DAKOTA BOARD OF PHARMACY

Intern Name _____

Intern No. _____

Enter the number of Practical Experience Hours earned each day, and submit this 2-page form to the Board office within five days of the end of this reporting period.

Month/Year _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly Total	MONTHLY TOTAL	

Month/Year _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly Total	MONTHLY TOTAL	

Month/Year _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly Total	MONTHLY TOTAL	

Month/Year _____

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Weekly Total	MONTHLY TOTAL	

Total Hours Submitted For This Reporting Period _____

Preceptor Signature (must be the same as on Affidavit)

Date