

# Application For Registration as a Pharmacy Intern

South Dakota Board of Pharmacy  
3701 West 49<sup>th</sup> Street, Suite 204, Sioux Falls, SD 57106  
605-362-2737  
Fee: \$40.00

*Please Print or Type*

Name: _____				
_____	_____	_____	_____	_____
Last	First	Middle	(Maiden)	
Address: _____				
_____	_____	_____	_____	_____
Street/PO Box	City	State	ZIP Code	
Phone: _____		E-Mail Address: _____		
Date of Birth: _____		Social Security Number: _____		
Name of College: _____		Expected Graduation Date: _____		

**I, the undersigned,** do hereby apply to the South Dakota State Board of Pharmacy for registration as a Pharmacy Intern, as provided in the rules of the South Dakota State Board of Pharmacy.

**I understand** that as a Registered Pharmacy Intern I may not perform any of the duties required of a registered pharmacist except when I am working under the continuous and personal supervision of a registered pharmacist and that my duties may not exceed those in guidelines provided by the Board.

**I also understand** that should I perform any duties, which I am not licensed to perform, or which exceed my educational level or if I falsely assume to be a pharmacist, or engage in any activity considered to be unprofessional conduct, I am placing my privilege of becoming a licensed pharmacist in South Dakota in jeopardy.

**I further understand** that I must submit records of my internship experience on forms provided by or prescribed by the Board and that credit for internship experience will not be granted unless registration and forms describing internship experience are completed and submitted to the Board in a timely manner.

**I also understand** that I am required to notify the Board if my address changes, while I am registered as an Intern.

*I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct, and that I accept the above statements.*

\_\_\_\_\_  
Signature of Intern Applicant

\_\_\_\_\_  
Date

## CERTIFICATION OF ELIGIBILITY FOR STUDENTS

Faculty Representative: \_\_\_\_\_

College of Pharmacy: \_\_\_\_\_

I, the undersigned do hereby certify that this student is registered at this college and has entered the first year of the Pharm.D Program.

\_\_\_\_\_  
Faculty Representative's Signature

\_\_\_\_\_  
Date