



SOUTH DAKOTA BOARD OF PHARMACY

4001 W VAHALLA BLVD, SUITE 106

SIOUX FALLS, SD 57106

Phone: (605) 362-2737

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www.pharmacy.sd.gov

Application for Registration as a Pharmacy Intern

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

FOR SD BOP USE ONLY

Received _____ Check # _____ Amount _____ Approved _____ Issued _____