

2019-2020 Intern Practical Experience Internship Hours

Intern Name _____ Intern # _____ Program Yr _____

Email _____

- 1** You must have a practical experience **affidavit** on file with the Board before 1st day of internship **AND** must file a new affidavit when changing internship locations, preceptors, or affidavit timeframe expires
 - 2** Submit **progress report of internship** form & this form to SD BOP **5 days** after the end date of reporting period
 - 3** For each late form (affidavit, progress rpt, intern hours), the total internship hours reported will be reduced by 5%
 - 4** **You cannot earn more than (8 hours) for any day worked**
 - For these days, the total combined hours you can earn per week is **(10 hours)**
 - For these days, the total combined hours you can earn per week is **(48 hours)**
 - * on this line, enter the TOTAL number of hours you worked for date above
- Report time rounded to the nearest half hour and as **(.5)** for 30 minutes

AUGUST 2019						
Su	M	Tu	W	Th	F	S
				1	2	3
*						
	4	5	6	7	8	9
*						
	11	12	13	14	15	16
*						
	18	19	20	21	22	23
*						
	25	26	27	28	29	30
*						

SEPTEMBER 2019						
Su	M	Tu	W	Th	F	S
1	2	3	4	5	6	7
*						
	8	9	10	11	12	13
*						
	15	16	17	18	19	20
*						
	22	23	24	25	26	27
*						
	29	30				
*						

OCTOBER 2019						
Su	M	Tu	W	Th	F	S
		1	2	3	4	5
*						
	6	7	8	9	10	11
*						
	13	14	15	16	17	18
*						
	20	21	22	23	24	25
*						
	27	28	29	30	31	
*						

NOVEMBER 2019						
Su	M	Tu	W	Th	F	S
					1	2
*						
	3	4	5	6	7	8
*						
	10	11	12	13	14	15
*						
	17	18	19	20	21	22
*						
	24	25	26	27	28	29
*						

DECEMBER 2019						
Su	M	Tu	W	Th	F	S
1	2	3	4	5	6	7
*						
	8	9	10	11	12	13
*						
	15	16	17	18	19	20
*						
	22	23	24	25	26	27
*						
	29	30	31			
*						

JANUARY 2020						
Su	M	Tu	W	Th	F	S
			1	2	3	4
*						
	5	6	7	8	9	10
*						
	12	13	14	15	16	17
*						
	19	20	21	22	23	24
*						
	26	27	28	29	30	31
*						

Total hours submitted for this reporting period: _____

Print Preceptor Name _____

Preceptor Signature _____
(must be the same signer as on Affidavit)

SD License # _____

Date _____

For Office Use

Affidavit	Y	N	L
Progress Rpt	Y	N	L
Same Preceptor	Y	N	
Form Signed	Y	N	A/P

Deduction _____
 Deduction _____
 Total Deduct _____
 Total Hrs Approved _____

Input _____

Scanned _____

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Email _____

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FEBRUARY 2020						
Su	M	Tu	W	Th	F	S
						1
*						
	2	3	4	5	6	7
*						
	9	10	11	12	13	14
*						
	16	17	18	19	20	21
*						
	23	24	25	26	27	28
*						
						29
*						

MARCH 2020						
Su	M	Tu	W	Th	F	S
1	2	3	4	5	6	7
*						
	8	9	10	11	12	13
*						
	15	16	17	18	19	20
*						
	22	23	24	25	26	27
*						
	29	30	31			
*						

APRIL 2020						
Su	M	Tu	W	Th	F	S
			1	2	3	4
*						
	5	6	7	8	9	10
*						
	12	13	14	15	16	17
*						
	19	20	21	22	23	24
*						
	26	27	28	29	30	
*						

MAY 2020						
Su	M	Tu	W	Th	F	S
					1	2
*						
	3	4	5	6	7	8
*						
	10	11	12	13	14	15
*						
	17	18	19	20	21	22
*						
	24	25	26	27	28	29
*						
	31					
*						

JUNE 2020						
Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
*						
	7	8	9	10	11	12
*						
	14	15	16	17	18	19
*						
	21	22	23	24	25	26
*						
	28	29	30			
*						

JULY 2020						
Su	M	Tu	W	Th	F	S
			1	2	3	4
*						
	5	6	7	8	9	10
*						
	12	13	14	15	16	17
*						
	19	20	21	22	23	24
*						
	26	27	28	29	30	31
*						

Total hours submitted for this reporting period: _____

Print Preceptor Name _____

Preceptor Signature _____
(must be the same signer as on Affidavit)

SD License # _____

Date _____

For Office Use

Affidavit	Y	N	L
Progress Rpt	Y	N	L
Same Preceptor	Y	N	
Form Signed	Y	N	A/P

Deduction _____
 Deduction _____
 Total Deduct _____
 Total Hrs Approved _____

Input _____
 Scanned _____