SOUTH DAKOTA BOARD OF PHARMACY

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Practical Experience Internship Affidavit

This form must be completed and on file with the Board of Pharmacy:

before your internship begins, and re-executed and submitted

- **a. when an internship location change occurs,**
- **b. a preceptor change occurs, or**
- **c. the affidavit time period covered expires**

Intern Name: ______________________________________ Registration No: _________ Program Yr: **P** _____

Maiden Name: ___________________________ Email: ____

Practical Experience Internship Site Information

This affidavit is for the following period and cannot exceed one year Start Date _____/_____/______ (mm/dd/yyyy)

End Date _____/_____/______ (mm/dd/yyyy)

Preceptor: __________________________________ License No.: ______________ State: ________

Pharmacy Name: ____

Address: ____ Phone: __________________

City/State/ZIP: ____

Explanation of Special Circumstances: ____

____

Intern Expectations and Responsibilities

By initialing each item, I affirm that I understand and will perform in accordance with the Board's expectations.

____ I will adhere to professional behavior and attire standards and wear a name badge at all times.

____ I will keep confidential all information and activities (pharmacy related, medical community, and customer) acquired during my practical experience internship and under no circumstance reveal any information.

____ I will seek help when needed and never hesitate to admit I do not know the answer.

____ I understand the primary aim of an internship is learning and that the process requires a continual, active commitment as well as an environment of mutual respect and courtesy among all parties.

____ I understand criticism is a constructive component of learning, and that I should never question the preceptor's advice or directions in public. Any disagreements should be addressed in private.

____ I am aware of all laws and rules governing pharmacy practice and will seek clarification when needed.

____ I will notify the Board of Pharmacy in compliance with ARSD 20:51:16:05(05) if I am asked to violate state/federal laws or have knowledge that the institution where completing practical experience violates such laws.

20:51:02:10. <u>Practical experience defined</u>. The term practical experience as it relates to qualification for licensure, means performing the practice of pharmacy as defined in SDCL 36-11-2.2 and the functions authorized to registered pharmacists in SDCL 36-11-19.1, all of which must be performed under the immediate and personal supervision of a registered pharmacist.

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.

______________________________________ ______________________

Pharmacy Intern Signature Date

Intern Name: ____

Registration No: ________________ Program Yr: **P** _______

Maiden Name: _______________________________________

Email: ____

Pharmacist Requirements

20:51:02:11. Supervising pharmacist requirements. A registered pharmacist who agrees to supervise the practical experience of a registered pharmacy intern must certify this on a form provided by the board and agree to abide by the South Dakota pharmacy law and the rules of the South Dakota Board of Pharmacy.

I have read the foregoing completed application of ___________________________________ whose internship training will have my immediate and personal supervision, and find that it accurately relates to the place of internship, which I deem is proper and in accordance with the regulations which are applicable, and other facts. I agree to abide by the Pharmacy Laws and Rules of the Board of Pharmacy in the state where practicing. ***Progress Report of Internship*** *forms will be signed by me and sent to the Board office within 5 days of end of internship.*

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.

____ ____________________

Pharmacist Preceptor Signature Date

____ ____________________

Print Pharmacist Preceptor's Name Pharmacist SD License No.