SOUTH DAKOTA BOARD OF PHARMACY
4001 W. Valhalla Boulevard, Suite 106, Sioux Falls, SD 57106
p - 605.362.2737 f – 605.362.2738
www.pharmacy.sd.gov email - pharmacyboard@state.sd.us

2025-2026 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 or preceptors
2. Submit **progress report of internship** form & **this form** to SD BOP **5 days** after the end date of reporting period
3. Late submission of affidavit & progress report will be docked 5% per item
4. Enter number of hours worked for day; report time to nearest half hour (.5) for 30 minutes

AUGUST 2025

Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

SEPTEMBER 2025

Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

OCTOBER 2025

Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

NOVEMBER 2025

Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

DECEMBER 2025

Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

JANUARY 2026

Su	M	Tu	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Total hours for August through January _____

Print Preceptor Name _____ **SD License #** _____

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

For Office Use

Affidavit	Y	N	L
Progress Rpt	Y	N	L
Same Preceptor	Y	N	

Deduction _____
Deduction _____
Total Deduct _____
Total Hrs Approved _____

Input _____
Scanned _____

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FEBRUARY 2026						
Su	M	Tu	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

MARCH 2026						
Su	M	Tu	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

APRIL 2026						
Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

MAY 2026						
Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

JUNE 2026						
Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

JULY 2026						
Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Total hours for February through July _____

Print Preceptor Name _____ **SD License #** _____

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

For Office Use

Affidavit	Y	N	L
Progress Rpt	Y	N	L
Same Preceptor	Y	N	

Deduction _____
Deduction _____
Total Deduct _____
Total Hrs Approved _____

Input _____
Scanned _____