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

2023-2024 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 submissions (affidavit & progress report) will be docked 5% per item
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 2023

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 2023

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 2023

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 2023

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 2023

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 2024

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 submitted for this reporting period: _____

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

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

For Office Use

Affidavit	Y	N	L	Deduction _____	
Progress Rpt	Y	N	L	Deduction _____	Input _____
Same Preceptor	Y	N		Total Deduct _____	
Form Signed	Y	N	A/P	Total Hrs Approved _____	Scanned _____

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   Report time rounded to the nearest half hour and as (.5) for 30 minutes

FEBRUARY 2024

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		
*						

MARCH 2024

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 2024

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 2024

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 2024

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 2024

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 submitted for this reporting period: _____

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

Preceptor Signature _____ **Date** _____

(must be the same signer as on Affidavit)

For Office Use

Affidavit	Y	N	L	Deduction _____	
Progress Rpt	Y	N	L	Deduction _____	Input _____
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Form Signed	Y	N	A/P	Total Hrs Approved _____	Scanned _____