ARIZONA STATE BOARD OF PHARMACY
P.O. Box 18520 Phoenix, AZ 85005
p) 602-771-2727 f) 602-771-2749
www.azpharmacy.gov

ANNUAL REPORT OF INTERN TRAINING

INTERN INFORMATION

Name: _____ **License #:** _____

Address: _____ _____ _____ _____
Street and Number **City** **State** **Zip**

Training Site: _____

Address: _____ _____ _____ _____
Street and Number **City** **State** **Zip**

Training Report for Year Ending December 31st of _____

Month	Year	* Hours Reported	** Signature of Preceptor	License Number
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
Total Hours Reported				

DO NOT WRITE IN THIS SECTION FOR BOARD USE ONLY!

Report Number _____

Total Hours Reported: _____

Total Hours Credited: _____

Validated by: _____

Date: _____

*** The following is to be completed by and ASBP, UofA, or Midwestern University Pharmacy Intern Preceptor:**

I hereby attest that I am a pharmacist who had been actively engaged in the practice of pharmacy in Arizona for at least one year and that I have supervised the intern training of the Pharmacy Intern listed at the top of this document. Experiential training records may be examined upon request by the State Board of Pharmacy or their compliance officers.

Preceptor Signature **Date:**