Reset a Form

AFFIDAVIT OF EXPERIENCE - PHARMACIST INTERN TRAINING PROGRAM

State Form 26877 (R5 / 2-06)

INDIANA BOARD OF PHARMACY
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2067
E-mail: pla4@pla.IN.gov

INSTRUCTIONS: *1. Affidavit to be completed by **LICENSED SUPERVISING PHARMACIST** of the Pharmacist Intern's training period.*
2. Practical experience time must be listed below on a calendar week basis showing actual time served each week.
3. Return form to: **Professional Licensing Agency**
402 West Washington Street, Room W072
Indianapolis, Indiana 46204

IMPORTANT NOTICE TO PERSONS WHO HAVE AFFIDAVITS EXECUTED OUTSIDE OF INDIANA

Each affidavit taken outside of this state must be accompanied by certification from the Board of Pharmacy in the state where served that such experience time is acceptable to that Board.

State in which affidavit executed	County in which affidavit executed	Date affidavit executed (*month, day, year*)

LICENSED PHARMACIST

Name of licensed pharmacist (*first, middle, last*)	State certified in	License number
Name of pharmacy employed		Permit number of pharmacy
Address of pharmacy employed (*number and street, city, state, and ZIP code*)		Telephone number ( )

PHARMACIST INTERN

Name of intern (*first, middle, last*)

Address of intern (*number and street, city, state, and ZIP code*)	Permit number of intern

WEEK(s) EMPLOYED (*ending on*)			NUMBER OF HOURS EMPLOYED EACH WEEK	WEEK(s) EMPLOYED (*ending on*)			NUMBER OF HOURS EMPLOYED EACH WEEK
Month	Day	Year		Month	Day	Year	

TOTAL number of weeks employed	**TOTAL** number of hours employed	**TOTAL** length of employment (*month, day, year*)
		From To

The above employment information was taken from payroll or other records which are kept at (*pharmacy name*):

AFFIDAVIT

On this day, I certify that I am a licensed pharmacist holding the certificate number listed above in the state certified in, and that the above named pharmacy intern, located at the address indicated, was in my employ, compounding and filing prescriptions for medical practitioners under my supervision for the total number of hours, and length of employment listed above for the above named pharmacy.

I solemnly swear, or affirm that the statements give above are true and correct to the best of my knowledge.

Signature of licensed pharmacist	Date signed (*month, day, year*)