University of Florida, College of Pharmacy

RECORD OF EXPERIENCE FOR

(Intern's Name) ______________________

(Intern's License No.) ______________________

(Address of Intern) ______________________

(Intern's Phone Number) ______________________

(City, State and Zip Code of Intern) ______________________

Under the immediate supervision of:

(Pharmacist Preceptor's Name) ______________________

(Pharmacist's License No.) ______________________

(Name of Pharmacy) ______________________

(Pharmacy Phone Number) ______________________

(Address of Pharmacy) ______________________

(City, State and Zip Code of Pharmacy) ______________________

Briefly describe the Intern's job duties:

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Week Beginning			Week Ending			Hours
Mo	Day	Year	Mo	Day	Year	
					HOURS INTERNED =	

(Pharmacist Signature/Date) ______________________

(Intern Signature/Date) ______________________

Please return completed form to:

College of Pharmacy
Office of Experiential Programs
Randell Doty, Pharm.D., Director
PO Box 100486 HSC
Gainesville, Fl 32610-0486
Tel: (352) 273-6228
Fax (352) 273-6498