

<b>PRACTICAL EXPERIENCE AFFIDAVIT</b>	<b>FORM # 0103</b>
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**ATTENTION INTERN!**

**TYPE OR PRINT LEGIBLY**

- > **YOU are responsible** for the complete and timely filing of all required internship forms and documents.
- > After completing this form, the Preceptor must verify its accuracy by hand-signing the statement in Sec. 4. Make a copy for your file and mail the original to the Board.

1. **FOR:** Ohio Pharmacy Intern License Identification Number: 06 – 0 –

(Type or print legibly **Intern's Name and Mailing Address** here)

**-- DEADLINE FOR FILING AFFIDAVITS --**

AFFIDAVITS MUST BE RECEIVED IN THE BOARD OFFICE **NO LATER THAN MARCH FIRST** OF THE YEAR FOLLOWING THE DATE THE HOURS WERE WORKED

The Board office will send a copy of the original to you stating the number of hours accepted at the bottom. If you do not receive the statement within 30 days, contact the Board office by telephone.

**2. TRAINING SITE**

Name of Training Site:	Drug Distributor License No.:
Street Address:	County:
City, State, Zip Code:	Area Code / Telephone Number:

**3. HOURS WORKED AT THIS SITE** (GIVE ONLY EXACT DATES THIS REPORT COVERS - Not Entire Work History)

BEGINNING DATE of This Report Period (Month/Day/Year)	ENDING DATE of This Report Period (Month/Day/Year)	TOTAL NO. OF HOURS Worked At This Site ONLY During This Report Period (Round to the nearest whole hour)
The above information was taken from payroll or other records which are kept at the following location and may be examined by any member or agent of the Board: (Give Number, Street, City)		

**4. DEPOSITION AND SIGNATURE OF PRECEPTOR**

Name of Preceptor:	R.Ph. I.D. Number: (if applicable)
I HEREBY STATE THAT THE INTERN NAMED ABOVE WAS TRAINED AT THE SITE LISTED ABOVE, WORKED THE HOURS REPORTED, AND PRACTICED IN ACCORDANCE WITH THE REQUIREMENTS OF THE OHIO PHARMACY PRACTICE ACT AND THE INTERNSHIP PROGRAM. I HEREBY CERTIFY, UNDER PENALTY OF OHIO REVISED CODE SECTION 2921.13, THE ABOVE STATEMENTS ARE TRUE AND CORRECT.	
SIGNATURE OF PRECEPTOR:	

**5. TO BE COMPLETED BY INTERN'S ACADEMIC ADVISOR OR DEAN ONLY IF ABOVE EXPERIENCE WAS OBTAINED AS PART OF A STRUCTURED ACADEMIC COURSE**

WHILE OBTAINING THE EXPERIENCE LISTED, THE INTERN NAMED ABOVE OBTAINED A PASSING GRADE FOR THE STRUCTURED ACADEMIC COURSE.		
SIGNATURE OF ACADEMIC ADVISOR OR DEAN:	DATE SIGNED:	NAME OF COLLEGE OR UNIVERSITY:

===== **FOR BOARD USE ONLY BELOW THIS LINE** =====

Date Statement Copy Returned:	Initials:	Hours Accepted This Report:	Total Accepted Hours On File:
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