

<b>STATEMENT OF PRECEPTOR</b>	<b>FORM # 0102</b>
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- ❶ Complete the form then the Preceptor must hand sign and date.
- ❷ Make a copy for your file.      ❸ Mail the original to the Board office.

**TYPE OR PRINT LEGIBLY**

THE INTERN IS RESPONSIBLE for the complete and timely filing of all required internship forms and documents

1. **FOR:** Ohio Pharmacy Intern License Identification Number: 06 - 0 - \_\_\_\_\_

(Enter Intern's Name and Mailing Address\* here)

**-- IMPORTANT \*\* PLEASE NOTE --**

Each pharmacy intern must file with the Board a Statement of Preceptor form within 30 days after beginning training under a preceptor's supervision.

No credit will be given for practical experience obtained prior to 30 days of the date that the Statement of Preceptor form is received by the Board office.

*\*Note: The Board office will return a copy to you as acknowledgement of receipt.  
 If the acknowledgement copy is not received within 30 days, contact the Board office by telephone.*

**2. TRAINING SITE:**

Name of Training Site:	Drug Distributor License No.:
Street Address:	Area Code / Telephone Number:
City, State, Zip Code:	County:
If the training site is owned by an individual other than the preceptor, has the owner, employer, or administrator approved training interns?	
Yes	No

**3. TYPE OF SITE:**

Community Pharmacy (Independent/Chain) Hospital Pharmacy Home Health Care Pharmacy Nuclear Pharmacy Other Pharmacy (specify):	Site Other Than A Terminal Distributor: <i>(Requires formal request submitted to the Board)</i> Manufacturer                      Consulting Wholesaler                              Drug Information Research                                  Drug Utilization Review Other (specify):
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**4. PRECEPTOR'S STATEMENT:**

Name of Person Supervising Experience:	R.Ph. I.D. No. (if applicable):	State Whether Owner, Manager, or Employee:
I STATE THAT I AM A REGISTERED PHARMACIST HOLDING A CURRENT AND ACTIVE LICENSE, OR THE PERSON SUPERVISING THE EXPERIENCE PURSUANT TO RULE 4729-3-05(E) OF THE OHIO ADMINISTRATIVE CODE. I HEREBY AGREE TO SERVE THE OHIO BOARD OF PHARMACY AS PRECEPTOR FOR THE INTERN NAMED ABOVE WHO HOLDS A CURRENT OHIO PHARMACY INTERN IDENTIFICATION CARD. I UNDERSTAND THAT AS THIS INTERN'S PRECEPTOR I AM RESPONSIBLE FOR SEEING THAT HE/SHE IS PROPERLY SUPERVISED WHILE PRACTICING PHARMACY AND THAT HE/SHE IS EXPOSED TO ALL ASPECTS OF THE INTERNSHIP PROGRAM. I FURTHER UNDERSTAND THAT I SHALL BE RESPONSIBLE FOR CERTIFYING THE PRACTICAL EXPERIENCE AFFIDAVITS REQUIRED BY THE BOARD OF PHARMACY AND SUBMIT REPORTS ON THE PROGRESS AND APTITUDE OF THE INTERN WHEN REQUESTED. I HEREBY CERTIFY, UNDER PENALTY OF SECTION 2921.13 OF THE REVISED CODE, THE ABOVE STATEMENTS ARE TRUE AND CORRECT.		
SIGNATURE OF PRECEPTOR:		DATE OF SIGNATURE:

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

Date Received In Office:	Date Acknowledgement Copy Returned:	Initials:
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