Steven W. Schierholt, Esq.
Executive Director

John R. Kasich
Governor

STATE OF OHIO BOARD OF PHARMACY

STATEMENT OF PRECEPTOR

Intern must complete the form – the Preceptor must hand sign and date in front of notary. Make a copy for your file, then mail the original to the Board office. The INTERN is RESPONSIBLE for the complete and timely filling of all required internship forms and documents.

1. ***FOR*** Ohio Pharmacy Intern License Identification Number: __**060**_____

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

Name:
Street Address:
City, State, Zip Code
E-mail:

****IMPORTANT – PLEASE NOTE****

Each pharmacy intern MUST FILE with the Board of Pharmacy 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 acknowledge via e-mail. If the acknowledgement copy is not received within 30 days, contact the Board office, preferably by e-mail.

2. ***TRAINING SITE***

Name of Training Site	DDD License #
Street Address	County
City, State, Zip Code	Area Code / Phone # Ext
If the training site is owned by an individual other than the preceptor, has the owner, employer, or administrator approved training interns? ☐ Yes ☐ No	

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3. ***TYPE OF SITE***

☐ Community Pharmacy (Independent/Chain) ☐ Hospital Pharmacy ☐ Home Health Care Pharmacy ☐ Nuclear Pharmacy ☐ Other Pharmacy (specify): _____	☐ Site Other Than A Pharmacy: *(Requires formal request submitted to the Board)* ☐ Manufacturer ☐ Consulting Wholesaler ☐ Drug Information ☐ Physician/Clinic ☐ Research ☐ Drug Utilization Review ☐ Other (specify): _____

4. ***PRECEPTOR'S STATEMENT***

Name of Person Supervising Experience	RPh ID # (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 OAC 4729-3-06. I hereby agree to serve the State of 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, that the number of interns engaged in the practice of pharmacy at any time is limited to not more than two for each pharmacist on duty, 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 ORC 2921.13, that the above statements are true and correct.

SIGNATURE OF PRECEPTOR	***DATE SIGNED***

Signature must be notarized.

Sworn to and signed before me this date:
(Date)
(Signature of Notary)

[Seal]

FOR BOARD USE ONLY

Date Received in Office	***Date Acknowledgement E-Mail Sent***	***Initials***