



CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF PHARMACY

TELEPHONE: (302) 744-4500
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AFFIDAVIT OF PRECEPTOR

INSTRUCTIONS

This form is for Delaware Pharmacist Intern applicants who are attending or graduated from a school or college of Pharmacy in the U.S.

- The applicant completes the **APPLICANT INFORMATION** section and sends this form to his or her selected Delaware-licensed preceptor Pharmacist.
- The preceptor completes the **INFORMATION ABOUT PRECEPTOR** section, signs the form in the presence of a notary and sends it *directly* to the Board office at the address above.

APPLICANT INFORMATION

Applicant Name: _____

INFORMATION ABOUT PRECEPTOR

1. Name of Preceptor Pharmacist: _____
2. Pharmacist License Number: A1 - _____
3. Have you practiced as a pharmacist at least two years? Yes No
4. Name of Pharmacy Where Intern Will Work: _____
5. Pharmacy Address: _____

 _____ City _____ ^{DE} State _____ Zip _____
6. Pharmacy's License Number: _____
7. Do you accept responsibility as the preceptor for the applicant named above? Yes No
8. Do you agree to provide the applicant with the experience outlined in the Board's [Practical Experience Program](#)?
Yes No
9. If you terminate your preceptorship agreement with the applicant, do you agree to notify the Board office within ten calendar days and to file an *Affidavit of Intern Experience* form? Yes No

AFFIDAVIT

I hereby certify that the information I have provided is accurate.

Signature of Preceptor: _____ Date: _____

City of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires: _____

Send this form *directly* to the Board of Pharmacy office at the address above.