



TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
BOARD OF PHARMACY
665 MAINSTREAM DRIVE
NASHVILLE, TENNESSEE 37243
(615) 741-2718 OR FAX (615) 741-2722
<http://health.state.tn.us/Boards/Pharmacy/>

INTERNSHIP AFFIDAVIT

NAME	<i>Last</i>	<i>First</i>	<i>Middle Initial</i>
			()
ADDRESS	<i>Street</i>	<i>Apt. Number</i>	<i>Phone Number</i>
			- -
	<i>City</i>	<i>State</i>	<i>Zip</i>
			<i>Intern's Social Security Number</i>

I hereby certify that the above named Pharmacist Intern was trained according to the requirements of the Rules and Regulations of the Tennessee Board of Pharmacy. I certify that these hours were acquired during my presence and under my personal supervision:

PRINT <i>Name of Pharmacist Preceptor</i>	<i>Name of Pharmacy</i>
<i>Address of Pharmacy</i>	<i>Pharmacy License Number</i>
	()
<i>City</i>	<i>State</i>
	<i>Zip</i>
	<i>Pharmacy Phone Number</i>

Beginning Month/Day/Year	Ending Month/Day/Year	Number of Hours

* Pay records may be attached (it is not a requirement) but a total must be entered in the number of hours square. The board will not be responsible for totaling the hours.
 Total Hours (all hours on this page) _____

_____ *Signature of Pharmacist Preceptor* _____ *License No.*
 NOTARY PUBLIC: I attest that the above signature (s) of _____
 sworn to and subscribed to before me this _____ day of _____,
 My commission expires _____ *Notary Signature* _____

* This form is for hours worked in Tennessee only.
 * Hours earned in states other than Tennessee must be certified to Tennessee by the Board of Pharmacy in the state where the work was performed.