The University of the State of New York
The State Education Department
Office of the Professions
Division of Professional Licensing Services
www.op.nysed.gov

Pharmacist Form 4
Certification of an Internship in Pharmacy

A separate Form 4 must be completed at the end of each internship session.

Submit this form ONLY if you are:

- An applicant providing certification of completed pharmacy practice as required by the Department; or
- a graduate of a non-accredited (foreign) program.

Do NOT submit this form if you are in an ACPE accredited program leading to a PharmD.

Section I: Intern Information

1. Social Security Number
   (Leave this blank if you do not have a U.S. Social Security Number)
2. Birth Date Month Day Year
3. Print Name Last
   First
   Middle

Licensee business address, phone and email address are public information. Failure to indicate business or home on this form for each item will deem it public information.

4. Mailing Address ☐ Home or ☐ Business
   (You must notify the Department within 30 days of any address or name changes)
   Line 1
   Line 2
   Line 3
   City
   State ZIP Code
   Country/ Province

5. Telephone/Email Address
   Daytime Phone
   ☐ Home or ☐ Business
   Area Code Phone
   Email Address (please print clearly)
   ☐ Home or ☐ Business

6. New York State DMV ID Number (Driver or Non-Driver ID)
   (Leave this blank if you do not have a New York State DMV ID Number)

7. Intern Permit Number ______________ Date permit issued: ____ mo. ____ day ____ yr.

8. College of Phramacy ______________
   Check one: ☐ B.S./BPharm degree ☐ PharmD Expected graduation date: ____ mo. ____ day ____ yr.

Section II: To be completed by the Preceptor Pharmacist

1. Name of Preceptor Pharmacist ______________
   Pharmacist License Number ______________ Date of Licensure ____ mo. ____ day ____ yr.
2. Registered Pharmacy Name ______________ Registration number ______________
   Pharmacy Address ______________
   Street
   ______________ *City* ______ *State* ______ *Zip Code*
   ______________ *Telephone* ______________ *Fax* ______________ *Email*
3. Provide the **exact** begin and end date for the internship hours being claimed on this form:
   Exact begin date ____ mo. ____ day ____ yr. **Exact** end date ____ mo. ____ day ____ yr. Hours per week: ______________
4. Total number of internship hours worked ______________ (Subject to audit. If audited, pharmacy payroll records must be submitted.)

Section III: To be signed by the Intern and Preceptor Pharmacist (Both signatures must be notarized by a Notary Public)

1. A valid New York State Pharmacy Intern Permit (required for internships completed in New York State only) for the intern named is/was displayed in this pharmacy (if not, attach an explanation).
2. The intern named has been instructed in the practice of pharmacy.
3. The internship has been carried out with the full knowledge and approval of the ownership of the pharmacy.
4. The internship hours accumulated are **in addition** to the hours required for both introductory and advanced practice rotations of the ACPE pharmacy curriculum.
5. Payroll records or other time records are available for verification of the internship.
6. The preceptor has practiced as a registered pharmacist **for one full year before** the beginning date of the internship specified.
7. The preceptor has supervised only one full-time or not more than two part-time interns during the period specified.
8. The pharmacy in which the internship has been completed dispensed more than 5,000 prescriptions annually pursuant to section 63.2(4) of the Education Law for each intern engaged in supervised practice.

The intern and preceptor signing this form attest under penalty of perjury that the total intern hours worked and indicated on this form (Section II, item 4) are true and accurate. False or misleading information may result in the disciplinary action being taken against both the intern and preceptor pharmacist. Were hereby affirm that the above statements are true and accurate.

Signature of Intern ______________________ Date ______________

Signature of Preceptor ______________________ Date ______________

Notary

State of ______________________ County of ______________________

On the ____________ day of ______________ in the year ____________ before me, the above signatores,

personally appeared ______________________ (*Applicant name*), and, ______________________ (*Preceptor name*) personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct**.**

Notary Public's Signature ______________________

Notary ID number ______________ Expiration Date ______________

Notary Stamp

Section IV: To be competed only if your are seeking approval to practice as an Intern Pharmacist in a state other than New York

Before you begin an internship in another state, confirm your eligibility to do so with that State's Board of Pharmacy.

Internships completed in another state may be accepted as long as the intern meets all requirements to practice pharmacy and is authorized to do so by that State's Board of Pharmacy. This section must be completed and signed by an authorized representative of the state in which the internship will be or has been performed. A separate Form 4 must be submitted for each pharmacy and each preceptor pharmacist.

The Board of Pharmacy of the State of ______________________ authorizes the above named individual to perform the duties of a pharmacy intern under the supervision of the above named preceptor pharmacist and at the pharmacy listed above.

Internship is/was allowed to commence on the following date: ______________________

Authorized Signature ______________________ Date ______________

Print Name ______________________

Title ______________________

Address ______________________

Telephone ______________ Fax ______________

Email ______________________

Seal

Mail this form to: New York State Education Department, Office of the Professions, Pharmacy Unit, 89 Washington Avenue, Albany, NY 12234-1000.