Washington State Department of Health

Pharmacist License for Foreign Graduates Application Packet

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Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Board of Pharmacy Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Washington State Department of Health

Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the required forms.

- [ ] **Application Fee.** This fee is non-refundable. You can check the online **fee page** for current fees.

- [ ] **1. Demographic Information:**
  Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

  Legal Name: List your full name: first, middle and last.

  Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

  Birth date: Provide the month, day, and year of your birth.

  Birth place: Provide the city, state and country where you were born.

  Address: List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

  Phone, Fax and Cell Numbers: Enter your phone, fax and cell numbers, if you have them.

  Email: Enter your email address, if you have one.

  Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

- [ ] **2. Personal Data Questions:**
  All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List all states, Washington, where credentials are or were held. Attach additional completed pages if you need more space.

☐ **4. Education and Training:**
List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

☐ **5. Experience:**
List in date order, most recent to later, all your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.

☐ **6. AIDS Education and Training Attestation:**
Read the AIDS education and training attestation. AIDS training may include self-study, direct patient care, courses, or formal training. A minimum of seven hours is required. Course content can be found in **WAC 246-12-270**.

☐ **7. Applicant’s Attestation:**
You must sign and date this for us to process the application.

☐ **8. Applicant’s Photograph:**
Attach a current photograph in the box provided or attach it to the application. Indicate date the photograph was taken and sign in ink across the bottom of the photo. The photograph must be a clear, close up and a front view. Your application will not be processed without a current photograph.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Washington State Department of Health

License Requirements for Foreign Graduates

This is information to apply for a pharmacist license by foreign graduate. For more information visit our **Web site**.

General Information

1. If your academic training in pharmacy is from a foreign country, you must take and pass the Foreign Pharmacy Graduate Equivalency Examination (FPGEE) and provide an education equivalency certification from the Foreign Pharmacy Graduate Education Commission (FPGEC). If you do not have your FPGEE score sheet and FPGEC certification, to begin the FPGEC application process, contact the National Association of Boards of Pharmacy (NABP) at **www.nabp.net**. When you have completed all of the necessary requirements, NABP will advise you to register for the FPGEE and TOEFL iBT (English language proficiency exam).
2. Washington State uses the North American Pharmacist License Exam (NAPLEX) to test your knowledge, judgment and skills as an entry-level pharmacist. Multistate Pharmacy Jurisprudence Examination (MPJE) tests you on both federal, state laws, and rules.
3. The Pre-NAPLEX practice examination is available on the NABP Web site at **www.nabp.net**.
4. You must submit a computerized exam registration form for both the NAPLEX and MPJE at **www.nabp.net** or mail it to 1600 Feehanville, MT. Prospect IL 60056. You may complete the registration forms and submit the payment by credit card, VISA or Master Card, at the NABP Web site. If you do not have a credit card and prefer not to register online, you can get the paper registration forms by sending a request with your name and address to our Customer Service Office at **hsqa.csc@doh.wa.gov**, or by calling 360.236.4700.
5. To receive your Authorization to Test (ATT):
   - Register with and pay exam fees to the NABP.
   - Submit all items required before testing to our office.
     Once the above steps have been completed, Washington State Board of Pharmacy (WSBOP) will then release your name to the NABP as “ready to test”. The NABP will send your ATT.
   - We will mail the test results to you. Contact Office of Customer Service at 360.236.4700 if you have questions about licensure in Washington State.

6. Intern hours must be earned in the United States. If you registered as an intern to earn these hours in Washington State, copies of the FPGEE score report and certificate must be sent with your intern application and a non-refundable fee. Practical experience gained in any other state must be certified by the board of that state in order to be accepted by the Washington State Board of Pharmacy.

   The number of intern hours you are required to report is based on your FPGEE score;

   75-90 .... 500—at least 1200 hours must be earned prior to the examinations.

   91-105 .... 1000—at least 800 hours must be earned prior to the examinations.

   106-120 .... 500—all hours must be earned prior to the examinations.

   Over 120................. 300—all hours must be earned prior to the examinations.

Board of Pharmacy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Requirements Checklist for Foreign Graduates

Name ____________________

Address ____________________

City ____________________ State ______ Zip Code ________

Dates indicate when we received the following items, the absence of a date indicates that we have not received the item.

Items required before intern registration:

______ Copy of your FPGEE score report.

______ (75 to 90 requires 1500 intern hours, at least 1200 before exam.

______ (91 to 105 requires 1000 intern hours, at least 800 before exam.

______ (106 to 120 requires 500 intern houts, all before exam.

______ (over 120) requires 300 intern hours, all before exam.

______ Copy of your FPGEC certificate.

______ State intern application with the nonrefundable fee. See online **fee page.**

______ Email from NABP verifying FPGEC certificate.

Items required before taking the NAPLEX and MPJE:

______ State pharmacist application with the nonrefundable fee. See online **fee page.**

______ Letter of recommendation.

______ Copy of your birth certificate or passport.

______ Copy of your diploma.

______ Certification of ____________ intern hours, we have recieved ____________ .

Required before pharmacist license:

______ Preceptor Evauation.

______ Intern site evaluation report.

______ 7 hours of AIDS education.

______ NAPLEX score, on ____________ you received a score of ____________ .

______ MPJE score, on ____________ you received a score of ____________ .

Please send in with your application and payment.

License # ____________ Issued ____________ Expires ____________

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Background Check Stamp Here

Date Stamp Here

Revenue: 0262010000

Pharmacy Intern Registration Application

Please type or print clearly. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions) ☐ Male ☐ Female

Name: First | Middle | Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record:

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

Registration #____________________ Date Issued____________________

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

State	License/Certification/Registration Type	License/Certification/Registration		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grand Fathered

4. Education and Training

List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		start (mm/yyyy)	end (mm/yyyy)

5. Experience

List in date order, most recent to later, all your work experience. Attach additional completed pages if you need more space.

Name and Location of Institution	From (mm/yyyy)	To (mm/yyyy)	Type of Experience or Speciality

6. Aids Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

7. Applicant's Attestation

I, ________________________________, declare under penalty of perjury under the laws of the state of
(Print name of applicant clearly)
Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated __________________ at ____
(mm/dd/yyyy) (City, state)

by:____
(Original signature of applicant)

8. Applicant's Photograph

Photo Here

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0262010000

Pharmacist License For Foreign Graduates Application

Please type or print clearly. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions) ☐ Male ☐ Female

Name: First | Middle | Last

Birth date (mm/dd/yyyy)

Place of birth: City | State | Country

Address

City | State | Zip Code | County

Country

Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record:

City | State | Zip Code | County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

License # ______________________________ Date Issued ______________________________

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ☐ ☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

State/ Jurisdiction	License/Certification/Registration Type	Method Licensed			License/Certification/Registration	
		Exam	Endorse	Grandfathered	Year issued	Number

4. Education and Training

List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Graduate School	Degree and Major	start (mm/yyyy)	end (mm/yyyy)

5. Experience

List in date order, most recent to later, all your professional experience. Attach additional completed pages if you need more space.

Name and location of institution	Type of experience	start (mm/yyyy)	end (mm/yyyy)

6. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested. **I understand I should provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

7. Applicant's Attestation

I, ____ , declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated ___________________________________ at _______________________________________
(mm/dd/yyyy) (City, state)

By: _______________________________________
(Signature of applicant)

8. Applicant's Photograph

Photo Here

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

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Board of Pharmacy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Letter of Recommendation

Date:_________________________

To Washington State Board of Pharmacy:

I hereby certify that I am a licensed pharmacist in good standing in the state of ___________, my credential number is:___________________. I further certify that I have been personally acquainted with________________________ for __________ months and years and to the best of my knowledge, I believe he or she is of good moral and professional character. I confirm that he or she is free from habits liable to interfere with his or her professional services. He or she is worthy of receiving a license to practice pharmacy in the State of Washington.

Remarks: ____

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____

Print name ___________________________Signature________________________

Street address ____

City _____________________________________State______Zip Code _________

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Board of Pharmacy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Intern Site Evaluation Report

This form must be submitted to the board upon completion of an internship experience. No internship hours will be accepted without this evaluation report pursuant to **WAC 246-858-050(1)**. If the internship experience exceeds twelve months, it is recommended this form be submitted annually.

Name of intern: ____

Name of preceptor: ____

Name of internship site: ____

Intern evaluation of preceptor: ____

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Intern evaluation of internship program at this site: ______________________________

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Signature of intern ______________________________ Date ____________________

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Board of Pharmacy Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Preceptor Evaluation and Certification of Experience

This form must be submitted to the board office at the completion of the internship experience. If the internship experience exceeds twelve months, it is recommended this form be filed annually.

Name of Intern		Year In school if applies ☐ 1 ☐ 2 ☐ 3 ☐ 4
Intern street address		
City	State	Zip
Name of preceptor		
Name of internship site		
Street address		
City	State	Zip

Preceptor Evaluation of Intern

Briefly describe the type of professional experience received under your supervision. Comment on the intern's communication skills, accuracy, professional attitude, dispensing skills, ability to evaluate and monitor therapy, and knowledge of pharmacy management. Also, pursuant to **WAC 246-858-070(3)**, provide your assessment of the intern's ability to practice pharmacy at this stage of his or her internship. Attach additional completed pages if you need more space

Signature of Preceptor________________________________ Date ________________________

For the Two-Week Period of			For the Two-Week Period of		
From (Sunday)	To (Saturday)	Hours	From (Sunday)	To (Saturday)	Hours
			Total internship hours____________________		

Note: Internship hours will not be accepted after the signature date.

Preceptor Certification of Experience

I,____certify I am a pharmacist licensed in the State of_____________________________. The above named intern practiced pharmacy under my supervision at_________________________________pharmacy, or under a special internship program. I certify the intern has completed goals set forth in the Washington State Board of Pharmacy Experiential Training Manual. The hours here recorded are correct, and to the best of my knowledge, the experience gained by the intern has been predominantly related to the practice of pharmacy as required by law.

Preceptor's signature________________________Date___________License number____________

RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act.. RCW 18.130

Administrative Procedure Act ....RCW 34.05

Administrative procedures and requirements .... WAC 246-12

Pharmacy RCW...RCW 18.64

Pharmacy WAC .... WAC 246-863

On-Line

AIDS Training Resources ....Reference Page

AIDS Education and
Training................. http://www.doh.wa.gov/cfh/hiv/prevention/training/default.htm

Pharmacy Board..Web Page

Required Hours of Training

Pharmacist..7 hours

Technician..4 hours

Assistant ....4 hours