State of Nebraska
DEPARTMENT OF HEALTH AND HUMAN SERVICES – DIVISION OF PUBLIC HEALTH
LICENSURE UNIT
P.O. BOX 94986, LINCOLN, NE 68509-4986
(402) 471-2118

AFFIDAVIT OF CLINICAL PHARMACY HOURS

Applicant's Name: _____
(First) (Middle) (Last)

Applicant's Address: _____
(Street) (City) (State) (Zip)

SSN: _____ DOB: _____

_____
(College/School of Pharmacy) (Address)

Total number of hours of clinical pharmacy-related courses applicable to internship time: _____.

I hereby certify that the foregoing number of hours of clinical pharmacy-related courses are applicable to the internship time of the above-named intern. I certify that the above time was obtained in the college/school during his/her enrollment as a pharmacy student.

Subscribed and sworn before me this _____ day of _____, _____

_____ _____
(Notary Public) (Signature of College/School Official, that is a Nebraska Licensed Pharmacist)

RETURN THIS FORM TO:

Nebraska Department of Health & Human Services
Licensure Unit
Attn: Pharmacy Desk
PO Box 94986
Lincoln NE 68509-4986