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 PHARMACY HOURS

Pharmacist Intern's Name _____
(First) (Middle) (Last)

Pharmacist Intern's Address _____
(Street)

_____
(City) (State) (Zip)

_____
(College/School of Pharmacy)

_____
(Address of College/School)

Pharmacist Intern # _____ Social Security # _____

Record of internship accumulated in this report: _____ Total Hours

From _____ to _____
(Month) (Day) (Year) (Month) (Day) (Year)

I hereby certify that the foregoing record of internship indicates the true record of training of the above-named intern under my supervision. I certify that it was achieved under my immediate personal supervision and that this affidavit accurately relates the places and duration of the intern's training.

Subscribed and sworn before me this _____ day of _____, 20_____

(Seal)

_____
(Signature of Licensed Pharmacist) (License #)

_____ _____
(Signature of Notary Public) (Name of Pharmacy) (License #)

_____, being duly sworn, deposes and says that the foregoing affidavit of internship to be true and correct.
Subscribed and sworn before me this _____ day of _____, 20_____

(Seal)

_____
(Signature of Applicant)

_____ _____
(Signature of Notary Public) (Commission Expires)

One of these forms must be completed at the <u>end of each training experience</u> outside of college/school and returned to:

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

07/29/08