Arkansas State Board of Pharmacy
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John Clay Kirtley, Pharm.D., Executive Director

TRAINING PLAN FOR AN INTERN PHARMACIST

Please note: You must have a *Training Plan* on file at the Board of Pharmacy in order to receive credit for experience hours. A *Buff Card* will be sent to the pharmacy listed on this *Training Plan* to allow you to work and gain pharmacy experience hours. **Do not work until the pharmacy has received the Buff Card.**

Please PRINT OR TYPE.

Social Security Number: _____ **Intern License #:** _____
Last First Middle

Name: _____

Physical Address: _____

City: _____ **State:** _____ **Zip:** _____

If different from physical address above.

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone Number: ( ) _____ **Daytime Phone Number: ( )** _____

Academic Classification: P1: ☐ P2: ☐ P3: ☐ P4: ☐

Type Of Practice: Community/Retail: ☐ Hospital: ☐ Research: ☐ Other ✳: ☐

✳If you checked "other", please describe here: _____

Pharmacy Name: _____

Pharmacy Permit #: (AR#####, HP#####) _____

Pharmacy Address: _____

City: _____ **State:** _____ **Zip:** _____

Pharmacy Phone Number: ( ) _____ **Pharmacy Fax Number: ( )** _____

Start Date for this Training Plan: _____

Expected End Date*: _____

I will be employed approximately _____ hours per week.

***NOTE: All training plans expire May 31 of each year.**

Intern Agreement:

Please carefully read and sign below.

I understand that, as an intern, I may not perform any duties required of a pharmacist except when I am working under the direct and personal supervision of a pharmacist preceptor. I also understand that should I perform any duties which I am not licensed to perform, or should I take charge of and operate a pharmacy in the absence of a pharmacist, I am placing my ability to become a licensed pharmacist in jeopardy.

I further understand that I must have a *Training Plan* on file at the Board of Pharmacy in order to receive credit for experience hours. A *Buff Card* will be sent to the pharmacy where I plan to gain pharmacy experience hours. I cannot work until the pharmacy has received the *Buff Card*.

I must submit a record of my intern experience on the *Affidavit of Experience*, certified by the pharmacist in charge under whose immediate supervision such experience was attained, if I expect to receive credit for such experience toward completion of my experience requirement.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the registration. I hereby certify under penalty of perjury under the laws of the State of Arkansas to the truth and accuracy of all statements and representations made in this application and that I personally completed the application. I understand that I must notify the Board in writing of any change of address during my internship. I have read and understand the instructions and statements on this application. I also understand that this training plan will automatically expire May 31st and that an affidavit of experience must be filed prior to that date to receive credit for these experience hours and that an additional training plan must be filed to continue working in a pharmacy as an intern until I have received credit for 500 hours as prescribed by the Arkansas State Board of Pharmacy.

Signature of Intern Pharmacist | Date

Pharmacist in Charge Agreement:

Please carefully read and sign below.

I accept the responsibility to ensure that _____ ,
(Please print or type the intern's name)
an intern pharmacist, will be physically and personally supervised by a preceptor pharmacist at all times when he/she is performing duties that are defined as the practice of pharmacy in this pharmacy. The intern pharmacist will work approximately ____ hours per week.

Pharmacist in Charge Name
(Please type or print)

Pharmacist in Charge Signature

Pharmacist in Charge License #

Date