

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 261-7083
Phone #: (608) 266-2112

Ship To: 1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

PHARMACY EXAMINING BOARD

CERTIFICATION OF POST-GRADUATE INTERNSHIP IN THE PRACTICE OF PHARMACY

APPLICANT: Complete this section and submit to supervising pharmacist for completion. Form must be returned directly from the supervising pharmacist to the Department at the above address.

Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Address: (number, street, city, zip code)

Date of Graduation: / /

SUPERVISING PHARMACIST: Complete this section and return directly to DSPS: You may fax/email with facility cover sheet/letter to: (608) 261-7083 or dspscredpharmacy@wisconsin.gov.

<input type="text"/>	<input type="text"/> - 40
Name of Supervising Pharmacist	Supervising Pharmacist WI License Number

Internship Location: (name, number, street, city, zip code)

I have directly supervised the applicant for a total of hours (limited to a maximum of 2000 hours) in a post-graduate internship in the practice of pharmacy.

The undersigned, having been duly sworn on oath, states that the facts and statements herein contained are true and correct based upon personal knowledge of the undersigned.

<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Signature of Supervising Pharmacist	Date