

Intern Declaration of Practice Experience

This declaration must be completed by the pharmacy intern's preceptor. The preceptor and site must have been approved by the NSCP in advance of the intern's practice experience. A separate application for preceptor and site approval must be submitted to the NSCP for approval before an intern can begin their practice experience; the *Preceptor/Site Approval Application* can be found on the NSCP website. Please note that unstructured time service must be completed in a direct patient care setting.

FULL NAME OF PHARMACY INTERN: _____

PRECEPTOR DECLARATION:

I, _____, a licensed pharmacist of
First and Last Name of Pharmacist

Pharmacy Name and Address

do certify and declare that:

- I am an active direct patient care pharmacist in good standing and without conditions on my licence with the:

Name of Provincial Regulatory Authority

Licence Number

and that the intern named above:

- completed their practice experience starting on the _____ day of _____, _____
Day Month Year
 and ending on the _____ day of _____, _____ for a total of _____ hours,
Day Month Year

and that during the practice experience period named above, said intern:

- was registered as an intern with the appropriate provincial regulatory authority the entire time;
- served under my direction in the pharmacy named above, and all laws, regulations and standards were observed;
- completed the hours named above prior to my completion of this form;
- practiced pharmacy directly with patients;
- demonstrated satisfactory language skills;
- demonstrated that they are a fit and proper person to practise pharmacy competently, safely and ethically;
- and (select one): ☐ **did satisfactorily meet** the requirements of the practice experience period.
☐ **did NOT satisfactorily meet**

I make this solemn declaration conscientiously believing it to be true and knowing that it is being relied on by the Nova Scotia College of Pharmacists for registration and other regulatory purposes in accordance with the Pharmacy Act.

Preceptor Signature: _____ Date: _____
DD / MM / YYYY