Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
Madison, WI 53705
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.

Last Name | **First Name** | **MI** | **Former / Maiden Name(s)**

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

Date of Graduation: ___ / ___ / ____

SUPERVISING PHARMACIST: Complete this section and return directly to DSPS. Supervising Pharmacist may mail to the address above or fax or email with facility cover sheet or cover letter to (608) 251-3036 or DSPSCredPharmacy@wisconsin.gov.

Name of Supervising Pharmacist

Supervising Pharmacist WI License Number - **40**

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 states the facts and statements herein contained are true and correct based upon personal knowledge of the undersigned.

Signature of Supervising Pharmacist **(Print and Sign Form)**

Date ___ / ___ / ____