Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Phone Number: (608) 266-2112

LicensE Portal: **License.wi.gov**
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Website: http://dsps.wi.gov

PHARMACY EXAMINING BOARD

VERIFICATION OF PRACTICAL EXPERIENCE INTERNSHIP IN THE PRACTICE OF PHARMACY

APPLICANT: Complete this section and submit to the Certifying Board or Agency for completion. Form must be returned directly from the Certifying Board or Agency to the Department. This form may be copied, and additional copies submitted if necessary.

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

Address (number/street)	(city)	(state)	(zip code)

Date of Graduation (mm/dd/yyyy)	**Application Number**
_____/ _____ / ____________	

ATTESTATION OF APPLICANT: I declare that I am the person referred to on this form and that all information required to be completed by me (the applicant for a credential), is complete and accurate to the best of my knowledge and belief. Furthermore, I declare that after completing the information that was required by me (and only that information) the form was forwarded to the relevant third-party for completion of the information asked of them. I also declare that to the best of my knowledge the completed form was provided to the Department of Safety and Professional Services by the relevant third-party (and not by me, the applicant). Finally, I declare that I understand that failure to provide the requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential may result in credential application processing delays; denial, revocation, suspension, or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. By signing below, I am signifying that I have read and understand the above declarations.

Applicant Signature (If unable to provide a digital signature, please print and sign form.)	**Date** (mm/dd/yyyy)
	_____/ _____ / __________

CERTIFYING BOARD: Complete this section and return directly to the Department using the LicensE Third-Party* Upload Portal at license.wi.gov. You will need the application number shown above. (*For form completion purposes, the term "Third-Party" refers to any non-applicant or non-DSPS individual or entity submitting required documentation in support of a credential application.)

Practical Experience Verification:

This verifies that the applicant has been granted ______________ hours of approved practical experience or internship credit by this Board or agency in this state in one or more of the following areas of pharmacy practice per Wis. Stat. § 450.01(16):

1. Interpreting prescription orders.
2. Compounding, packaging, labeling, dispensing, and the coincident distribution of drugs and devices.
3. Participating in drug utilization reviews.
4. Proper and safe storage of drugs and devices and maintaining proper records of the drugs and devices.
5. Providing information on drugs or devices, which may include, but is not limited to, advice relating to therapeutic values, potential hazards and uses.
6. Drug product substitution under applicable state and federal law.
7. Supervision of pharmacist supportive personnel.
8. Making therapeutic alternate drug selections, in accordance with written guidelines or procedures previously established by a pharmacy and therapeutics committee of a hospital and approved by the hospital's medical staff and use of the therapeutic alternate drug selection has been approved for a patient during the period of the patient's stay within the hospital by any of the following: The patient's physician; The patient's APNP, if the APNP has entered into a written agreement to collaborate with a physician; or The patient's physician assistant.

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Certifying Board completion, continued.

9. Making therapeutic alternate drug selections in accordance with written guidelines or procedures previously established by a quality assessment and assurance committee of a nursing facility under Wis. Stat. § 49.498(2)(a)(3) or by a committee established for a nursing home under Wis. Stat. § 50.045(2), if the use of the therapeutic alternate drug selection has been approved for a patient during the period of the patient's stay within the nursing facility or nursing home by any of the following; The patient's personal attending physician; or The patient's physician assistant, if the physician assistant is under the supervision of the patient's personal attending physician.
10. Making therapeutic alternate drug selections in accordance with written guidelines or procedures previously established in rules promulgated by the corrections system formulary board under Wis. Stat. § 301.103, if the use of the therapeutic alternate drug selection has been approved for a prisoner, as defined in Wis. Stat. § 301.01(2), during his or her period of confinement in a state correctional institution, as defined in Wis. Stat. § 301.01(4), by any of the following: A physician; an APNP; or A physician assistant.
11. Drug regimen screening, including screening for therapeutic duplication, drug-to-drug interactions, incorrect dosage, incorrect duration of treatment, drug allergy reactions and clinical abuse or misuse.
12. Performing any act necessary to manage a pharmacy.
13. Administering prescribed drug products and devices under Wis. Stat. § 450.035(1r) and vaccines.

ATTESTATION OF THIRD-PARTY PROVIDING INFORMATION RELATED TO APPLICANT: I declare, on behalf of the third-party asked to provide information related to the applicant identified on this form, that the information provided is true and correct to the best of my knowledge and belief. I further declare that after completing the form I, or other third-party staff, will provide the completed form directly to the Wisconsin Department of Safety and Professional Services for review. By signing below, I am signifying that I have read, understand, and have complied with the above declarations.

Signature (If unable to provide a digital signature, print and sign form.)			**Date**
			_____/ _____/ ___________
Printed Name			**Certifying State**
Title			**Phone**
Address (number/street)	(city)	(state)	(zip code)

Committed to Equal Opportunity in Employment and Licensing