



South Carolina Department of Labor, Licensing and Regulation

South Carolina Board of Pharmacy

110 Centerview Dr. • Columbia • SC • 29210

P.O. Box 11927 • Columbia • SC 29211-1927

Phone: 803-896-4700 • [Contactllr@llr.sc.gov](mailto:Contactllr@llr.sc.gov) • Fax: 803-896-4596



**AFFIDAVIT OF PRACTICAL EXPERIENCE**

This form is for internship hours earned in South Carolina only

Form to be submitted when either occurs:

- 1-within 10 days after the end of each employment
- 2-within 10 days after transferring within the same company
- 3-within 10 days after the beginning of each new year

<u>For Board use only</u>	
<u>Date received</u>	
<u>Hours accepted</u>	
<u>Total hours</u>	

*Proviso 81.11. The Board of Pharmacy must accept affidavits of practical experience from interns whose practical experience internships occurred in this State. The affidavit must provide that the supervising pharmacist and the site of experience is licensed and in good standing with the board and that the internship falls within the criteria for internships set by the board. The affidavit must be accompanied by a ten dollar (\$10) fee to cover administrative costs associated with compliance with this proviso.*

**Include \$10 check or money order ONLY payable to SC Board of Pharmacy. DO NOT MAIL OR BRING CASH TO THE OFFICE. The supervising pharmacist's signature must be notarized.**

Please print.		
<u>Intern Name:</u>		
<u>Mailing address:</u>		
<u>Mailing address city:</u>	<u>State:</u>	<u>Zip code:</u>

**AFFIDAVIT OF LICENSED PHARMACIST UNDER WHOSE SUPERVISION INTERN WORKED**

This is to certify that I am \_\_\_\_\_,  
(Name of Supervising Pharmacist)

a licensed pharmacist in the state of **South Carolina** with license number \_\_\_\_\_ and that

\_\_\_\_\_ with Intern Certificate Number \_\_\_\_\_  
(Name of Intern)

was under my supervision, direction, and instruction from \_\_\_\_\_ through \_\_\_\_\_

at the \_\_\_\_\_  
(Name and Location of Pharmacy)

\_\_\_\_\_ with permit number \_\_\_\_\_.  
(City, State and Zip Code)

During the period of practical experience, the Intern named herein was engaged in the practice of pharmacy under my supervision. The experience gained by the intern was in accordance with the SC Pharmacy Practice Act. I certify that all statements given herein are true and correct to the best of my knowledge.

Signed: \_\_\_\_\_  
(Supervising Pharmacist)

(NOTARY STAMP)

Subscribed and sworn to before me this \_\_\_\_\_  
(Date)

Notary Public Signature: \_\_\_\_\_

My commission expires: \_\_\_\_\_

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I certify that all of the information contained herein is true and correct, and that all hours listed on the reverse were completed before this Affidavit was signed.

\_\_\_\_\_  
(Signature of Intern)

Date: \_\_\_\_\_

**Log of Intern Hours for \_\_\_\_\_**

Year

**It is the sole responsibility of the Intern to insure that this form is completed and returned to the Board within the required period of time. Lack of knowledge of laws and regulations does not constitute an acceptable excuse.**

**No more than 40 hours of internship training will be allowed per week. Indicate actual hours worked such as 8, 8.25, or 8.5. Board staff will determine acceptability.**

A total of 1,500 hours of experience is required for licensure. Students enrolled in an approved Doctor of Pharmacy program consisting of six or more years of collegiate studies may receive credit for up to 1,000 hours for practice related experiences upon completion of such program, none of which shall be used to fulfill the requirements that a minimum of 500 hours of practical experience must be obtained in a retail or institutional pharmacy. Reporting of the 1,000 hours will be done on the Certification of Externship Rotations form which shall be completed by the Dean of the College of Pharmacy and submitted by the applicant for licensure along with the examination application.

**Enter the number of internship hours worked daily.**

Day	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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31												
<b>Total</b>												

Print Name: \_\_\_\_\_ Intern Number \_\_\_\_\_