



Newfoundland & Labrador Pharmacy Board

Apothecary Hall
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Supervised Studentship Preceptor's Certification of Completion

Student Name: _____ Expected Year of Graduation: _____

Preceptor: _____

Pharmacy & Location: _____

Actual Start Date(s)	Actual End Date(s)	Total Weeks (at 35 hours per week)	For Office Use Only Weeks Credited (Min. 4 weeks and Max. 8 weeks)

➤ Please account for any breaks (i.e. vacation, study, etc.) by detailing the weeks the student/intern was actually present at the pharmacy using the above table

CERTIFICATION OF STUDENTSHIP

I certify that _____ has completed the Studentship
(Student's Name)

period described above while under my preceptorship. I further certify that this Studentship was served according to the guidelines and requirements of the Joint Committee on Structured Practice Experience of the Newfoundland and Labrador Pharmacy Board and the Memorial University of Newfoundland School of Pharmacy.

Preceptor's Signature: _____ Date: _____

Note: Should you have concerns about the ability of this Student to adequately perform the duties of a Pharmacy Student at a level appropriate to their stage of pharmacy education and training, you should feel obligated to make those concerns known to the Secretary-Registrar.

This form **MUST** be returned to the Newfoundland & Labrador Pharmacy Board
NO LATER THAN August 31st in the year the weeks were completed
in order to receive credit for the time served.