

## Pharmacy Technician Internship Documentation Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number \_\_\_\_\_

Location: \_\_\_\_\_

Clinical Site

A. \_\_\_\_\_

B. \_\_\_\_\_

C. \_\_\_\_\_

School Number: \_\_\_\_\_

Coordinator: \_\_\_\_\_

***Use separate form for Retail and Hospital Internship***

Clinical Area/Site	Date	Time In	Time Out	Number Of Hours	Description of Patient Management	Staff Signature

Total Hours This Sheet: \_\_\_\_\_ Total Hours All Sheets: \_\_\_\_\_ Coordinator's Signature: \_\_\_\_\_