Pharmacy Technician Internship Documentation Form

Name: ______________________________

Address: ______________________________

Last Four Social Security Number: ______________________________

Location: ______________________________

School Name: ______________________________

Use separate form for each Ambulance and/or Hospital Internship

☐ Internship Site

A. ______________________________

B. ______________________________

C. ______________________________

School Number: ______________________________

Coordinator: ______________________________

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: ______________________________