Pharmacy Technician Internship Documentation Form

Name: _____

Address: _____

Social Security Number _____

Location: _____

Use separate form for Retail and Hospital Internship

Clinical 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: _____