Name: _____

Intern Permit # : _____

TOTAL HOURS: _____

Please indicate total hours per day, per month and grand total. (round to the nearest quarter hour)

The affidavit and this form must be submitted to the board office at least 30 days following the last day worked for the time period being submitted.

Return to:

Kansas State Board of Pharmacy

Landon State Office Building

900 Jackson, Room 560

Topeka, KS 66612

(785) 296-4056

Hours can only be obtained after being registered with the Kansas Board of Pharmacy.

The preceptor must be licensed in Kansas.

Make a copy of affidavit and this form before sending into the Kansas Board of Pharmacy.

To obtain credit for these hours requires completion of this page and the first page with your preceptor's notarized signature.

MONTH: _____ YEAR: _____ HOURS: 0.00

SUN	MON	TUE	WED	THU	FRI	SAT

MONTH: _____ YEAR: _____ HOURS: 0.00

SUN	MON	TUE	WED	THU	FRI	SAT

MONTH: _____ YEAR: _____ HOURS: 0.00

SUN	MON	TUE	WED	THU	FRI	SAT

MONTH: _____ YEAR: _____ HOURS: 0.00

SUN	MON	TUE	WED	THU	FRI	SAT