



**PHARMACY INTERN NOTIFICATION OF EMPLOYMENT**

This form is for internship hours worked in South Carolina only.

Log into your account via online services to upload this completed form.

**SC Code 40-43-85(A)** An intern shall notify the Board of Pharmacy within ten days after the beginning and again within ten days after the ending of each and every calendar year, if the intern is employed, and within ten days after the beginning of each new employment and within ten days after the ending of each employment, on forms provided by the board, of the identity of the internship site and of the designated pharmacist. This form must be certified by the designated pharmacist. The pharmacy intern is responsible for the submission of the appropriate forms within the time limits as set.

This form must be completed and submitted to the Board office:

1. Within 10 days of beginning of each new employment as an Intern.
2. Within 10 days of the beginning of each year.
3. Within 10 days after transfer within the same company or floating with the same company.

Log into your account to upload this completed document <https://eservice.llr.sc.gov/DocumentSubmission/> for Board review.

**PHARMACY INTERN:**

Name: \_\_\_\_\_ Certificate Number: \_\_\_\_\_

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

**SUPERVISING PHARMACIST:**

Name: \_\_\_\_\_ License Number: \_\_\_\_\_

**PHARMACY/ INTERNSHIP INFORMATION**

Pharmacy: \_\_\_\_\_ Permit Number: \_\_\_\_\_

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

Pharmacy Phone: \_\_\_\_\_ Start Date of Internship: \_\_\_\_\_

**SUPERVISING PHARMACIST:**

I hereby certify that the above listed pharmacy intern began employment under my personal supervision, direction and instruction of the practice of pharmacy on the date indicated. I further certify that the experience gained by the intern shall be in accordance with Chapter 43 of the South Carolina Code of Laws and Regulations promulgated thereunder.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervising Pharmacist Signature

**PHARMACY INTERN:**

I hereby certify that I began employment under the personal supervision, direction and instruction of the above listed licensed pharmacist in the practice of pharmacy on the date indicated. I understand it is my responsibility to ensure this notification form is completed and sent to the Board office within the required period of time or I will not receive credit for hours worked if a notification form is not provided at the beginning of each year.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Pharmacy Intern Signature