Alberta College of Pharmacy

Student/Intern
Work Experience Notification Form

This form is for use by any student or intern who is working in an Alberta hospital or community pharmacy outside of a recognized structured practical training program provided either by the Alberta College of Pharmacy or the University of Alberta Faculty of Pharmacy and Pharmaceutical Sciences.

This form must be completed and submitted to ACP if you are any one of the following and wish to perform Pharmacy Student or Pharmacy Intern restricted activities:

1) a UofA student working in a pharmacy outside of UofA rotations;
2) a UofA intern who continues to work in a pharmacy after completing level 3 of the ACP online structured practical training program;
3) a student enrolled in a Canadian Pharmacy program completing rotations in Alberta;
4) a student enrolled in a Canadian Pharmacy program working in an Alberta pharmacy;
5) an intern who graduated from a Canadian Pharmacy program who continues to work in an Alberta pharmacy after completing level 3 of the ACP online structured practical training program;
6) an IPG intern who continues to work in a pharmacy after completing the ACP structured practical training program (1000 hours); or
7) a pharmacist who is licensed in another Canadian province completing rotations (PharmD students) or completing a residency or working in an Alberta pharmacy while in the process of obtaining full licensure in Alberta.

Please submit this form to ACP prior to beginning your work experience. A form is required for each new work location. Fax: 780.990.0328 or Email: registrationinfo@abpharmacy.ca

Student/Intern

Name: _____

ACP Registration Number (must be registered with ACP): _____

Employment Start Date:_____ Employment End Date: _____

Name of Pharmacy: _____ Pharmacy License No. _____

Pharmacy Address: _____

City/Town: _____ Postal Code: _____

_____ _____
Date Signature of Student/Intern

Preceptor

I, _____ have agreed to accept _____
(name of preceptor) (name of student/intern)

as a student/intern and provide supervision in a clinical setting for the period indicated above.

I understand and agree that the student/intern named above will practice under my professional liability insurance.

_____ _____ _____
Date Signature of Preceptor ACP Reg Number