Employer’s Certification of Pharmacy Training Hours
(For Non-IPPE/APPE Hours)

Please print legibly to ensure proper credit

I hereby certify that I ____________________________ am a licensed pharmacist and was employed by:

Pharmacy Name _______________________________________________________________

Pharmacy Address _____________________________________________________________

Pharmacy Phone Number ________________________________________________________

At the time when ___________________________________ was in our employ or training for

Student Pharmacist Name ______________________________________________________

_______ hours during the time period of ___/___/___ to ___/___/___ (not to exceed six
months).

_________  ____________________________  ________
Pharmacist’s Signature (signed AFTER hours accrued)  Date

This Employer’s Certification of Pharmacy Training Hours shall be submitted to the Assistant Dean for
Experiential Education’s secretary by the student pharmacist at the termination of each training period or site
location.

Experience time will not be officially entered until this form is submitted by the student pharmacist. The form
must be submitted within thirty (30) days of the ending date of the training period.

Please note: To ensure proper documentation and to avoid problems that may arise, please submit your form at
least once every six months when training or working at a single site for an extended period of time.

Submit form via mail or fax to:
Office of the Assistant Dean for Experiential Education
Campus Stop 8333
Pocatello ID 83209-8333
Fax 208.282.4305