



# Pharmacist License for Foreign Graduates Score Transfer Application Packet

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## Important Social Security Number Information:

If you have a Social Security Number, the law requires you to disclose it on your application for a professional or occupational license. [42 U.S.C. § 666\(a\)\(13\)](#); [RCW 26.23.150](#). It will be used under the state’s child support enforcement program to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing support obligations. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. If you do not have a Social Security Number, you are still eligible to apply for and obtain a credential if you meet the requirements. Please see the Declaration of No Social Security Number Form. Please call the Customer Service Center at 360-236-4700 if you have questions.

## In order to process your request:

**Mail your application with initial documentation and your check or money order payable to:**

Department of Health  
 PO Box 1099  
 Olympia, WA 98507-1099

**Send other documents not sent with initial application to:**

Pharmacy Quality Assurance  
 Commission Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877

## Contact us:

360-236-4700

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## Application Instructions Checklist

**Important background check Information:** Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be printed clearly in blue or black ink. It is your responsibility to submit the required forms.

- Application Fee.** This fee is non-refundable. You can check the online [fee page](#) for current fees.
- Select if the following applies:**
  - Spouse or Registered Domestic Partner of Military Personnel
- 1. Demographic Information:**
  - Social Security Number:** You must list your social security number on your application. You are not required to have or obtain a Social Security Number to apply for or obtain a license from the Department of Health. Please see the [Declaration of No Social Security Number Form](#). Please call the Customer Service Center at 360-236-4700 if you do not have one.
  - National Provider Identifier Number (NPI):** The National Provider Identifier (NPI) is a standard unique identifier for health care professionals available from the Federal Centers for Medicare and Medicaid Services. The NPI is a 10 digit numeric identifier. If you have a NPI number, provide this on your application.
    - Legal Name:** List your full name: first, middle, and last.
    - Definition of legal name:** “Legal name” is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.
    - Birth date:** Provide the month, day, and year of your birth.
    - Address:** List the address we should use to send any information about your license. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See [WAC 246-12-310](#).
    - Phone, Fax and Cell Numbers:** Enter your phone, fax and cell numbers, if you have them.
    - Email:** Enter your email address, if you have one. To expedite notice to the applicant, we will use the email address as the primary contact source to update the applicant on the status of their application. It is important to ensure the email address is correct and current at all times.
    - Other Name(s):** Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

**2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.
- Another jurisdiction means any other country, state, federal territory, or military authority.

**3. Other License, Certification, or Registration:**

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space. You must also print the [Verification Form](#) and provide it to each state or jurisdiction that you have listed, requesting that they complete and submit the form directly to the Department of Health.

**4. Education and Training:**

List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

**5. Experience:**

List in date order, most recent to later, all your professional experience and practice from date of graduation from professional college. Attach additional completed pages if you need more space.

**6. Applicant’s Attestation:**

You must sign and date this for us to process the application.

**For Spouses and Registered Domestic Partners of Military Personnel Being Transferred or Stationed in Washington:**

Under state law, if you are the spouse or state-registered domestic partner of a servicemember of any branch of the U.S. Military, to include Guard or Reserve, and are applying for a health care professional credential in this state, you may be eligible to have the processing of your application expedited to receive your credential more quickly.

Documents to submit with your application should include the following:

- A copy of your spouse’s or registered domestic partner’s military transfer orders to Washington State.
- One of the following:
  - A copy of your marriage certificate to show proof of marriage; or
  - A copy of a state’s declaration or registration showing you are in a state registered domestic partnership with a member of the U.S. military.

## License Requirements

This is information to apply for a pharmacist license by foreign graduate through score transfer process. For more information visit our [website](#).

Note: All non-English documents must be translated before sending copies to the commission.

### General Information

1. If your academic training in pharmacy is from a foreign country, you must take and pass the Foreign Pharmacy Graduate Equivalency Examination (FPGEE) and provide an education equivalency certification from the Foreign Pharmacy Graduate Education Commission (FPGEC). If you do not have your FPGEE score sheet and FPGEC certification, to begin the FPGEC application process, contact the National Association of Boards of Pharmacy (NABP) at <https://nabp.pharmacy/>. When you have completed all of the necessary requirements, NABP will advise you to register for the FPGEE and TOEFL iBT (English language proficiency exam).
2. Washington State uses the North American Pharmacist License Exam (NAPLEX) to test your knowledge, judgment and skills as an entry-level pharmacist. Multi state Pharmacy Jurisprudence Examination (MPJE) tests you on both federal, state laws, and rules.
3. Applicants taking the licensing examination in another state for the purpose of score transfer to Washington must submit the same documentation, fees, intern hours and reports as a person taking the licensing exam in Washington. The licensing requirements must be completed within one year from the date the commission received score transfer notification from the National Association of Board of Pharmacy.
4. The Pre-NAPLEX practice examination is available on the NABP Website at <https://nabp.pharmacy/>.
5. You must submit a computerized exam registration form for both the NAPLEX and MPJE at <https://nabp.pharmacy/> or mail it to 1600 Feehanville, MT. Prospect IL 60056. You may complete the registration forms and submit the payment by credit card, VISA or Master Card, at the NABP Website. If you do not have a credit card and prefer not to register online, you can get the paper registration forms by sending a request with your name and address to our Customer Service Office at [hsqa.csc@doh.wa.gov](mailto:hsqa.csc@doh.wa.gov), or by calling 360-236-4700.
6. To receive your Authorization to Test (ATT):
  - Register with and pay exam fees to the NABP.
  - Submit all items required before testing to our office.  
Once the above steps have been completed, the Washington Pharmacy Quality Assurance Commission will then release your name to the NABP as “ready to test”. The NABP will send your ATT.
  - We will notify you of your test results. Contact Office of Customer Service at 360-236-4700 if you have questions about licensure in Washington State.

- Reporting internship hours: Qualifying internship hours must be earned under the personal supervision of a preceptor/licensed pharmacist, in a licensed pharmacy in the United States. The pharmacist's license and preceptor certification (if applicable) is active and in good standings. Use the preceptor Evaluation and Certification of Experience and Intern Site Evaluation forms to report these hours to the Washington State Pharmacy Quality Assurance Commission for each location.



Pharmacy Quality Assurance  
 Commission Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Requirements Checklist

This is information to apply for a pharmacist license by foreign graduate through score transfer process.

Note: Use this checklist as a tool to track information as you sent items to the commission.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Items required before taking MPJE:

\_\_\_\_\_ State pharmacist application with the nonrefundable fee. See online [fee page](#)

\_\_\_\_\_ Official transcripts or copy of your diploma from pharmacy school.

\_\_\_\_\_ Copy of your FPGEE score report.

\_\_\_\_\_ Copy of your FPGEC certificate.

\_\_\_\_\_ Score transfer report from NABP.

\_\_\_\_\_ Email from NABP verifying FPGEC certificate. This is done by the Pharmacy Quality Assurance Commission.

\_\_\_\_\_ Preceptor Evaluation.

\_\_\_\_\_ Intern site evaluation.

\_\_\_\_\_ Certification of a minimum fifteen hundred pharmacy internship hours.

### Required before pharmacist license:

\_\_\_\_\_ NAPLEX score, on \_\_\_\_\_ you received a score of \_\_\_\_\_.

\_\_\_\_\_ MPJE score, on \_\_\_\_\_ you received a score of \_\_\_\_\_.

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## Pharmacy Intern Registration Application

Please print clearly. Follow the instructions as provided. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

**Applying For (mark only one):**     ACPE Graduate     Graduate of school outside US  
 Current ACPE Pharmacist Student    School Name \_\_\_\_\_ Enrollment Date \_\_\_\_\_  
 Out of State Pharmacist enrolled in Residency Program     Commission Requires Additional Practical Experience

**Select if the following applies:**     Spouse or Registered Domestic Partner of Military Personnel

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer <input type="checkbox"/> X
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Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address if different from above address of record

City	State	Zip Code	County
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Country

**Note:** The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)?     Yes     No    If yes, list name(s):

Will documents be received in another name?     Yes     No    If yes, list name(s):

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**If you have been granted certificate(s) of restoration of opportunity, please provide a certified copy of each certificate.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**

## 2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

## 3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

State/ Jurisdiction	License/Certification/Registration Type	License/Certification/Registration		Method of Licensure		
		Year Issued	Number	Exam	Endorse	Grand Fathered

## 4. Training and Education

List in date order, most recent to later, all your training and education. Attach additional completed pages if you need more space.

Full Name, City and State/Schools Attended	Degree Earned	Attendance	
		Entrance Date	Ending Date

## 5. Experience

List in date order, most recent to later, all your work experience. Attach additional completed pages if you need more space.

Name and Location of Institution	From (mm/yyyy)	To (mm/yyyy)	Type of Experience or Speciality

## 6. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of the state of  
(Print name of applicant clearly)

Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ at \_\_\_\_\_  
(mm/dd/yyyy) (Original signature of applicant)

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Revenue: 0262010000

## Pharmacist License Application

Please check the appropriate box:

- |  |   |
|--|---|
| <input type="checkbox"/> By Exam (NAPLEX) for New Graduates                    | <input type="checkbox"/> By Score Transfer for U.S. Graduates               |
| <input type="checkbox"/> By Exam (NAPLEX) for Foreign Graduates                | <input type="checkbox"/> By Score Transfer for Foreign Graduates            |
| <input type="checkbox"/> By License Transfer/Reciprocity for Foreign Graduates | <input type="checkbox"/> By License Transfer/Reciprocity for U.S. Graduates |

Select if the following applies:  Spouse or Registered Domestic Partner of Military Personnel

### 1. Demographic Information

<b>Social Security Number (SSN)</b> (If you do not have a SSN, see instructions)	<b>National Provider Identifier Number (NPI)</b> (Enter 10 digit number)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer Not to Answer <input type="checkbox"/> X
---	---	--

Name	First	Middle	Last
------	-------	--------	------

Birth date (mm/dd/yyyy)

Address

City	State	Zip Code	County
------	-------	----------	--------

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)
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Email address

Mailing address if different from above address of record

City	State	Zip Code	County
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Country

**Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.**

Have you ever been known under any other name(s)?  Yes  No

If yes, list name(s):

Will documents be received in another name?  Yes  No

If yes, list name(s):

## 2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation.....

**“Medical Condition”** includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.  
1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

**Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.**

**The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.**

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain.....

**“Currently”** means within the past two years.

**“Chemical substances”** include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?.....

4. Are you currently engaged in the illegal use of controlled substances?.....

**“Currently”** means within the past two years.

**Illegal use of controlled substances** is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

**Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.**

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ...

**Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.**

**To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.**



## 2. Personal Data Questions (cont.)

Yes No

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? .....
  - b. Diverted controlled substances or legend drugs? .....
  - c. Violated any drug law? .....
  - d. Prescribed controlled substances for yourself? .....
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements? .....
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? .....
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? .....
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? .....
11. Have you ever been disqualified from working with vulnerable persons by the Department of Social and Health Services (DSHS)? .....

## 3. Other License, Certification, or Registration

List all states, including Washington, where credentials are or were held. Attach additional completed pages if you need more space.

State/ Jurisdiction	License/Certification/Registration Type	Method Licensed			License/Certification/Registration	
		Exam	Endorse	Grandfathered	Year issued	Number

## 4. Education and Training

List in date order, most recent to later, all your educational preparation and post-graduate training. Attach additional completed pages if you need more space.

Graduate School	Degree and Major	start (mm/yyyy)	end (mm/yyyy)

## 5. Professional Experience

List in date order, most recent to later, all your professional experience. Attach additional completed pages if you need more space.

Name and location of institution	Type of experience	start (mm/yyyy)	end (mm/yyyy)

## 6. Applicant's Attestation

I, \_\_\_\_\_, declare under penalty of perjury under the laws of  
(Name of applicant)  
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.
- I have read all laws and rules related to my profession.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local, or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated \_\_\_\_\_ By: \_\_\_\_\_  
(mm/dd/yyyy) (Original signature of applicant)

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Pharmacy Quality Assurance  
 Commission Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Intern Site Evaluation Report

Note: This form must be submitted to the commission office upon completion of an internship experience. No internship hours will be accepted without this evaluation report pursuant to [WAC 246-965-162](#). If the internship experience exceeds twelve months, it is recommended that this form be submitted annually.

Name of Intern:	Credential #
Name of Preceptor:	
Preceptor Certificate Number:	
Preceptor Location Address:	
Preceptor License Number:	
Name of Internship Site:	
Intern evaluation of preceptor:	
Intern evaluation of internship program at this site:	
Signature of Intern	Date:

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Washington State Department of  
**HEALTH**  
 Pharmacy Quality Assurance Commission  
 Credentialing  
 PO Box 47877  
 Olympia, WA 98504-7877  
 360-236-4700

## Preceptor Evaluation & Certification of Experience

This form must be submitted to the commission at the completion of the internship experience. If the internship experience exceeds twelve months, it is recommended that this form be filed annually.

Name of Intern		
Year In School <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Credential #	
Intern Street address		
City	State	Zip Code
Name of Preceptor		
Name of Internship Site		
Street Address		
City	State	Zip Code
<b>Preceptor Evaluation of Intern</b>		
Briefly describe the type of professional experience received under your supervision. Comment on the intern's communication skills, accuracy, professional attitude, dispensing skills, ability to evaluate and monitor therapy, and knowledge of pharmacy management. Also, pursuant to <a href="#">WAC 246-945-163(4)</a> , provide your assessment of the intern's ability to practice pharmacy at this stage of his or her internship. Attach additional completes pages if you need more space.		
Signature of Preceptor		Date







## **RCW/WAC and Online Website Links**

### **RCW/WAC Links**

[Uniform Disciplinary Act, RCW 18.130](#)

[Administrative Procedure Act, RCW 34.05](#)

[Administrative Procedures and Requirements, WAC 246-12](#)

[Pharmacy Laws, RCW 18.64](#)

[Pharmacy Rules, WAC 246-945](#)

### **Online**

[Pharmacy Quality Assurance Commission, Web Page](#)