

INTERN EVALUATION OF PRECEPTOR

NAME OF INTERN: _____	LICENSE #: _____
NAME OF PRECEPTOR: _____	LICENSE #: _____
NAME OF PHARMACY: _____	PHONE #: _____
ADDRESS OF PHARMACY: _____	

Please print or type all information

This evaluation is to be completed annually or when you leave the employ of the above-named preceptor. All sections should be completed in full.

If you need additional space for comments or suggestions, please use a separate page.

You should evaluate the preceptor/training according to the criteria listed below. All information submitted will be kept confidential.

During your training were you:

	ALWAYS	SOMETIMES	NEVER
Properly supervised by the preceptor			
Able to communicate with the preceptor			
Instructed in dispensing procedures			
Motivated to perform your best			
Recognized for jobs well done			
Constructively criticized			
Encouraged to discuss problems with preceptor			
Able to easily reference laws, regulations and other reference materials			
Required to strictly comply with laws and regulations			
Aware of your responsibilities			
Aware of preceptors responsibilities			
Allowed to make decisions within your realm of knowledge			
Encouraged to communicate with your co-workers / customers			
Instructed in drug produce uses / effects			
Able to apply your education / knowledge			

Personal Evaluation:

1. Do you feel the internship training program is properly preparing you to accept the responsibilities of a pharmacist? _____
2. Are there any areas in which you feel you were not properly or effectively instructed / directed? _____
3. What if any, suggestions would you make to your preceptor to improve the internship training program? _____

This is to certify that I was supervised / instructed by the above name preceptor from ____/____/____ to ____/____/____, and that all statements made are true and correct.

Signature of Intern

Date