

Name of Student _____ Intern Number _____

Student's Email Address _____

Preceptor's Email Address _____

Preceptor's License number _____

Samford _____ Auburn _____ Other _____ (check one)

If other-- name of pharmacy school _____

Name/Address of Pharmacy _____

Total of **NON-CURRICULUM HOURS** _____

Starting Date _____ Ending date _____

By signing this form, you are stating that the above is true and correct.

Signature of preceptor _____

Email hour form to: LMartin@albop.com