CPPCI-01, Rev 6/14

For Official Use Only

STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
DRUG CONTROL DIVISION
Email: DCP.PharmacistLicense@ct.gov
Web Site: www.ct.gov/dcp/cop

Pharmacy Intern Application

INSTRUCTIONS:
All spaces must be completed - please print or type. This application **must be accompanied by a check or money order in the amount of $60.00** made payable to *"Treasurer, State of Connecticut."* **Application fees are non-refundable.**

➔ Return your completed application and fee to:
Department of Consumer Protection, License Services Division, 165 Capitol Avenue, Hartford, CT 06106

The Commission of Pharmacy must be informed of the place of internship and the name of the preceptor (supervising registered pharmacist) within **five (5) days** of the beginning and termination of any internship experience. The identification number and card shall become void and shall be returned to the Commission of Pharmacy if the applicant does not complete the requirements for graduation from or terminates his enrollment at, an accredited and approved school or college of pharmacy.

First Name	Middle Initial	Last Name	☑ Male ☐ Female
Residence Street Address		City / State	Zip Code
Telephone Number (w/ area code)	Email Address	Social Security Number	Date of Birth

"The Federal Privacy Act of 1974 requires that you be notified that disclosure of your Social Security Number is required pursuant to C.G.S. §17b-137a. If you choose not to disclose your Social Security Number your application cannot be processed."

Name of Pharmacy School			
Street Address	City	State	Zip Code
Name of Pharmacy where you are employed as an Intern			
Street Address	City	State	Zip Code
Name of Preceptor (Print)	Signature of Preceptor	CT License Number	

To be completed by school or college of pharmacy.
For Graduates of an Accredited College of Pharmacy Only

This is to certify that _____ has completed two (2) years of college and is enrolled in the professional program at _____
Name of College of Pharmacy

Expected Date of Graduation: _____

Certified By: _____ _____
Print Name of Dean/Registrar Signature Dean/Registrar

I solemnly swear that the information contained herein is true and correct to the best of my knowledge, and I am aware that my pharmacy intern registration may be suspended or revoked if I violate any pharmacy laws, rules or regulations, or any provision of the Connecticut Commission of Pharmacy Code of Ethics, and hereby affix my signature as acknowledgment and agreement of such terms.

_____ _____
Signature of Intern Date

School Seal