

Wyoming State Board of Pharmacy
1712 Carey Avenue, Suite 200
Cheyenne, WY 82002
307.634.9636 (telephone)
307.634.6335 (facsimile)

**PHARMACY INTERN
RENEWAL APPLICATION**

Renewal fee: \$15.00 made payable to the Wyoming State Board of Pharmacy

An Intern license may not be renewed beyond 24 months from the date of graduation from a school or college of pharmacy where the initial degree in pharmacy was obtained, unless a waiver is obtained from the board. The fee for renewal of Intern license shall be \$15.00. The place of employment and the name of the registered pharmacist serving as the preceptor of the Intern shall be supplied to the Board.

Wyoming State Board of Pharmacy, Rules and Regulations, Chapter 3, Pharmacy Internship Regulations, Section 2(b).

Name: _____ Pharmacy Intern License Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number(s): _____ Email: _____

School/College of Pharmacy: _____

Current year of study in School/College of Pharmacy:

- 1st professional year (P1) 2nd professional year (P2)
 3rd professional year (P3) 4th professional year (P4)

Expected date of graduation: _____

If graduated, degree and date conferred: _____

Place of employment: _____

Preceptor: _____

As a Pharmacy Intern, I understand that I shall:

- Be responsible for understanding and complying with Wyoming State Board of Pharmacy, Rules and Regulations, Chapter 3, Pharmacy Internship Regulations, as well as all relevant Federal and State laws.
- Provide the Board office with all changes in Intern preceptors and Intern employers. This notification is not required when participating in the University of Wyoming Clinical Clerkship Program.
- Not compound or dispense drugs or medicine except under the immediate and personal supervision of a registered pharmacist in good standing with the Board.
- Be responsible for renewing my Pharmacy Intern license annually. I understand I will need to maintain a Pharmacy Intern license if I will be working as a Pharmacy Intern in Wyoming in any capacity.

Pharmacy Intern Signature

Date

For Board use only.

Date received: _____ Amount paid: _____ Check number: _____ Date certificate mailed: _____