

MINNESOTA BOARD OF PHARMACY
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PRECEPTOR REGISTRATION RENEWAL

Please print all information clearly

Name: _____ License No.: _____
Address: _____ Phone No.: _____
City: _____ State: _____ Zip: _____

PRECEPTOR SITE:

Site Name: _____ License No. (If applicable): _____
Address: _____ Phone No.: _____
City: _____ State: _____ Zip: _____

Preceptors are required to provide time for the purpose of helping the intern meet the competencies of the internship requirement. Do you agree to do this?

Yes No

FOR REGISTRATION RENEWALS

Have you attended an instructional program, specifically for preceptors, provided by or approved by the Board within the past 24 months?

Yes No

If yes, please attach a copy of your certificate of completion with this renewal and complete the following information:

Site of Course:

Date of Course:

Preceptor's Signature

Date