The Pharmacy Professionals Externship Preference Sheet

Student Name: _____
Legal name, nick name may be indicated in parentheses

Full Address: _____
include zip code

Phone Number(s): _____ **Languages (spoken/written)**_____
include area code

Days/Time Available: please insure to report any changes to your schedule as changes transpire.

- List times you are available to start and your end time and indicate if AM or PM.
- If you are unavailable place an "X" in both start and end boxes.
- If you are available anytime write the word "any" in both boxes.

DAYS	MON	TUE	WED	THUR	FRI	SAT	SUN
START							
END							

STUDENTS ARE NOT PERMITTED TO CONTACT PHARMACIES REGARDING YOUR DESIRE TO FULFILL YOUR EXTERNSHIP HOURS!

Please list 3 Pharmacies you would like to have considered to complete your externship hours. Please note we will take your choices into consideration. The decision is based on the pharmacy, their needs, and your availability.

1. **Pharmacy:** _____

   Address: _____

   Phone Number: _____

   Contact Person: _____
   if prior relation, otherwise DO NOT CONTACT PHARMACY

2. **Pharmacy:** _____

   Address: _____

   Phone Number: _____

   Contact Person: _____
   if prior relation, otherwise DO NOT CONTACT PHARMACY

3. **Pharmacy:** _____

   Address: _____

   Phone Number: _____

   Contact Person: _____
   if prior relation, otherwise DO NOT CONTACT PHARMACY

Please return to this form to your Program Director, Sonia Ruiz via email at thepharmacyprofessionals@gmail.com