MINISTRY OF HEALTH

NAME OF INTERNSHIP SITE: _____

CERTIFICATE OF PHARMACY INTERNSHIP

This is to certify that Dr. _____ _has successfully completed an internship program lasting _____ in the following pharmacy disciplines:

1. **Clinical Pharmacy**
   Duration:_____
   Ward(s):_____
   Under the supervision of: _____
   Qualifications: _____
   Supervisor's Signature: _____

2. **Infectious Diseases (HIV/TB/MDR TB)**
   Duration: _____
   Under the supervision of: _____
   Qualifications: _____
   Supervisor's Signature: _____

3. **Supply Chain Management**
   Duration: _____
   Under the supervision of: _____
   Qualifications: _____
   Supervisor's Signature: _____

4. **Community Pharmacy / National Warehouses / NDA / Pharmaceutical Industries / Cardiology / Oncology / Radiopharmacy / Other Specialized Offsite Pharmacy Areas**
   Duration: _____
   Facility Name: _____
   Under the supervision of: _____
   Qualifications:_____
   Supervisor's Signature:_____

Internship Site Supervising Pharmacist
Name: _____
Qualifications: _____
Signature: _____

Hospital Director
Name: _____
Signature: _____

Date: _____