PHARMACY COUNCIL OF THE GAMBIA
No. 112 Kairaba Avenue
Fajara , KMC
Tel: 4495572, 2022272 P.O.Box 4527 Bakau
Website: www.gpc.gm

PRECEPTOR INTERNSHIP REPORT

This form must be completed by the preceptor and be submitted to the Pharmacy Council of The Gambia in due time.

INTERNSHIP DETAILS

Intern Name			
Internship site			
Site Address			
Preceptor name			
Registration number		**Email**	
Dates covered by report (from - to)			

WEEKLY WORKING HOURS (including pharmacy practice seminars, etc)

From (Date)	**To** (Date)	**Number of Hours**	**From** (Date)	**To** (Date)	**Number of Hours**

Evidence on working hours is available at the internship site.

INTERN COMPETENCY ASSESSMENT

Please rate the intern on the following items using the scale below:
1 = Performs at a **High Level**, **2** = Performs **Satisfactorily**, **3** = Needs **Improvement**, **4** = Not Applicable

1.	Intern's performance of technical functions	☐ **1** ☐ **2** ☐ **3** ☐ **4**
2.	Intern's communication with patients	☐ **1** ☐ **2** ☐ **3** ☐ **4**
3.	Intern's communication with health care professionals	☐ **1** ☐ **2** ☐ **3** ☐ **4**
4.	Intern's communication with preceptor	☐ **1** ☐ **2** ☐ **3** ☐ **4**
5.	Intern's ability as counsellor	☐ **1** ☐ **2** ☐ **3** ☐ **4**
6.	Intern's ability as a teacher	☐ **1** ☐ **2** ☐ **3** ☐ **4**

Please comment on the intern's overall progress during this internship period:

(if space provided is not enough, please use separate page)

Please comment on the areas in which the intern needs further training:

(if space provided is not enough, please use separate page)

DECLARATION:
I, the undersigned certify that the information concerning the internship indicated herein is correct and true.

Signature of Preceptor: ..... **Date:** .....

OFFICIAL USE

DATE OF RECEPTION:		**STAMP**
NAME OF RECEIVER:		
NAME OF REGISTRAR		
REMARKS/RECOMMENDATIONS BY REGISTRAR		
Signature: ..... **Date:**		