

North South University



PHR522-Advance Pharmacy Practice Experiences (APPE)
A report on Hospital Pharmacy Internship

Department of Pharmaceutical Sciences
School of Health & Life Sciences (SHLS)

Approval
Hospital Pharmacy Training

The Hospital Pharmacy Training has been completed at _____ (name of the organization, City _____) from _____ to _____

This report is submitted to the Department of Pharmaceutical Sciences, North South University and has been accepted as satisfactory for partial fulfillment of the requirement for the degree of Bachelor of Pharmacy Professional (B. Pharm Professional).

Submitted By

Name of the Student:

ID Number:

Couse: PHR522-Advance Pharmacy Practice Experiences (APPE)

Advised Semester with year:

Section:

Head of the Committee

(Write here the name of the Supervisor
(Write here the designation of the Supervisor)
Department of Pharmaceutical Sciences
North South University

Declaration

- 1) I hereby declare that my report is an original piece of work.
- 2) I declare that to my knowledge no part of this work has been published anywhere before.
- 3) The report does not contain material that has been accepted or submitted for any other degree or diploma at this university or other institution.
- 4) I also declare that after publication in a peer-reviewed/ indexed journal, my research work will be considered as open to public property.
- 5) I have acknowledged all the main sources of help.

Signature of the Student

Name of the Student

Certificate of Hospital Pharmacy Training



North South University



PHR522-Advance Pharmacy Practice Experiences (APPE)

A report on Model Pharmacy Internship

Department of Pharmaceutical Sciences
School of Health & Life Sciences (SHLS)

Approval
Model Pharmacy Training

The Model Pharmacy Training has been completed at _____ (name of the organization, City _____) from _____ to _____

This report is submitted to the Department of Pharmaceutical Sciences, North South University and has been accepted as satisfactory for partial fulfillment of the requirement for the degree of Bachelor of Pharmacy Professional (B. Pharm Professional).

Submitted By

Name of the Student:

ID Number:

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Head of the Committee

(Write here the name of the Supervisor
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Signature of the Student

Name of the Student

Certificate of Model Pharmacy Training

