Pharmacist/Pharmacy Technician Self Assessment

Name:_____ **Date:_____**

Registered Pharmacist **Pharmacy Technician**

Please complete the following checklist relative to your professional experience. Be assured this checklist will be used in assessing your clinical proficiency in certain areas.

Level of Experience:

A - No Experience
B – Intermittent Experience
C – One Year of Consistent Experience
D – Two Years of Consistent Experience
E – Able to Teach and Supervise

TYPES OF SETTINGS	A	B	C	D	E
Acute Hospitals:					
Inpatient					
Outpatient					
Trauma/Emergency Room					
Critical Care					
Acute Rehabilitation					
Subacute Facility					
Skilled Nursing Facility					
Long Term Care Facility					
Home Health					
Retail					
Medical Practices					
Other:					
PRACTICE SETTINGS					
Pediatrics					
Psychiatric					
Endocrinology					
Diabetes					
Nuclear Medicine					
Pharmaco Therapy					
Oncology					
Nutritional Support					
Other:					
COMPUTER SYSTEMS					
1.					
2.					
3.					

ADDITIONAL INFORMATION

Please list any other areas in which you feel you have extensive experience not included in the skills survey.

_____
_____
_____
_____
_____
_____

LICENSES HELD

State	Number	Exp. Date		State	Number	Exp. Date

CERTIFICATIONS

Certification	Number	Date Certified	Expiration Date

This information I have given is true and accurate to the best of my knowledge. In addition, I hereby authorize (insert agency name) to release this Skills Checklist to client institutions in relation to my assignment with that institution/facility.

_____ _____
Signature Date

_____
Name – Please print