AMERICAN MEDICAL STAFFING

PHARMACIST SKILLS CHECKLIST

Instructions: Please indicate in the space below the number of years/months experience you have in the following procedures or protocols. Leave blank any areas in which you are not familiar or experienced. Please provide accurate answers so we can correctly match your abilities with client's request.

Last Name:_____ First Name:_____

Soc. Sec. #_____ Date:_____

Signature:_____

PHARMACIST – HOSPITAL	**YEARS**	**MONTHS**
Pharmak on 2000		
Pyxix Rx 2000		
Chemotherapy		
Compounding		
Consulting		
Nuclear Pharmacy		
Dispensing		
IV Preparation		
Hyper Alimental		
TPNs		
Home Health		
Meditech		
PHARMACIST – RETAIL	**YEARS**	**MONTHS**
Pharmak on 2000		
Pyxis Rx 2000		
Consulting		
Dispensing		
Rx Express		
PDX		
Other		