Pharmacy 445
Community Pharmacy-based Immunization and Health Screening Programs
University of Washington Department of Pharmacy
Preceptor's Evaluation Form

Student's Name __________________________  Pharmacy Name __________________________

1. Did the student arrive on time?  Yes □  No □

2. Was the student appropriately dressed?  Yes □  No □
Did (s)he wear a white jacket?  Yes □  No □
Did (s)he wear a name tag?  Yes □  No □

3. Did the student communicate well with
   Patients?  Yes □  No □
   Other health professionals?  Yes □  No □

4. Was the student adequately prepared for this experience?  Yes □  No □

5. If this student were an applicant for a position in your pharmacy, would you consider the application positively on the basis of the practicum experience?  Yes □  No □

6. What type of patient care experiences did the student participate in?
   Immunizations □  Blood glucose meter training □
   Cholesterol screening □  Patient counseling □
   Bone density screening □  Other: __________________________

7. Do you have any comments about this experience that could make it more meaningful for the student, for your patients, or for you, or suggestions for preparing future students? (Please use the other side if you need space to write).

Preceptor's Name (please print): __________________________  Preceptor Number: __________________________

Preceptor's Signature: __________________________  Preceptor's phone number: __________________________

Thank you very much for your help.

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As you know, the practice of pharmacy has inherent risks in working with patients with communicable diseases. It is important to be aware that you will bear the costs of any testing or treatment should you have a high risk exposure to diseases such as tuberculosis, hepatitis or AIDS, including needlesticks. Under today's prevention protocols, these costs may reach $3600 or more. The School of Pharmacy strongly encourages you to have health and disability insurance to cover these costs. By state law, we cannot require you to have any form of insurance, but hope you will look carefully into the options available to you and subscribe to the insurance policies that best fit your needs and those of your family, if applicable.

We are not in a position to advise you on particular insurance policies, the specifics of health or disability insurance benefits or how claims may be managed.

The University of Washington School of Pharmacy

With my signature below, I acknowledge having read this information and understand that coverage for health care for me, my family if applicable, and for disability is my individual responsibility.

Name ___________________________ (print)

Signature ___________________________

Date ____________