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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