

# Shadowing Experiences Form

*College of Pharmacy and Allied Health Professions  
Box 2202C  
South Dakota State University  
Brookings, SD 57007-0099*

**This form must accompany the Application for Admission into the SDSU Doctor of Pharmacy Professional Program**

## **What are pharmacy shadowing experiences?**

Shadowing refers to an experience in which a student observes a pharmacist and/or participates in some tasks related to pharmacy practice for the purpose of learning about the day-to-day professional responsibilities of a pharmacist in that particular practice setting. Working in a pharmacy in some capacity, such as a pharmacy technician, is included as shadowing experiences.

## **How much shadowing is necessary to satisfy the College of Pharmacy and Allied Health Professions application requirement?**

Shadowing experiences (which includes Pharmacy employment) are required as part of the application process for the pharmacy professional program. The Admissions Committee of the College believes that shadowing (or work) experiences are valuable for the student to discover more about the profession. The minimum requirement is to shadow a pharmacist at **1 pharmacy practice setting for 8 hours**. Shadowing for 8 hours satisfies this portion of the application requirement at the minimum level. Shadowing beyond the minimum requirement is encouraged.

*(This form may be copied and used to document additional shadowing experiences.)*

## **What is the purpose of this form?**

Use this form to record and document the hours of shadowing (or employment) experiences obtained and include the form with the application for the professional program.

Student's Name \_\_\_\_\_  
Last First Middle

Student's Permanent Address \_\_\_\_\_  
Street, RR, or Box City State Zip Code

# Shadowing Experiences Form

Student's Name (please print) \_\_\_\_\_

Shadowing Experience #1 \_\_\_\_\_

*Name of Professional Practice Site*

\_\_\_\_\_  
*Address of Professional Practice Site*

\_\_\_\_\_  
*Date(s) of Shadowing Experience(s) at this site*

\_\_\_\_\_  
*Approximate Number of Total Hours*

\_\_\_\_\_  
*Name of Pharmacist*

\_\_\_\_\_  
*Signature of Pharmacist*

\_\_\_\_\_  
*Date*

Applicant, please make comments concerning your shadowing experience:

Shadowing Experience #2 \_\_\_\_\_

*Name of Professional Practice Site*

\_\_\_\_\_  
*Address of Professional Practice Site*

\_\_\_\_\_  
*Date(s) of Shadowing Experience(s) at this site*

\_\_\_\_\_  
*Approximate Number of Total Hours*

\_\_\_\_\_  
*Name of Pharmacist*

\_\_\_\_\_  
*Signature of Pharmacist*

\_\_\_\_\_  
*Date*

Applicant, please make comments concerning your shadowing experience: