



Pharmacist-Assisted Technician Self-Instructional Modules (PATSIM)

Worksite Coordinator

PLEASE print or type

Date: \_\_\_\_\_ Practice Site \_\_\_\_\_

Name: \_\_\_\_\_

Email: \_\_\_\_\_

Pharmacy License Number: \_\_\_\_\_

Position or Title: \_\_\_\_\_

Pharmacy /Technician School Attended: \_\_\_\_\_

Degree Received: \_\_\_\_\_ Year graduated: \_\_\_\_\_

License/State(s): \_\_\_\_\_ PTCB Certification Expiration Date \_\_\_\_\_

Advanced Study

College	Location	Years Attended	Degree
_____	_____	_____	_____
_____	_____	_____	_____

Experience in Pharmacy Practice during the Previous Ten Years

Location	Position/Title	Dates
_____	_____	_____
_____	_____	_____

Membership in Professional Organizations

NDSHP  Yes  No      NDPhA  Yes  No

ASHP  Yes  No      APhA  Yes  No

AAPT  Yes  No      NAPT  Yes  No

Other: \_\_\_\_\_



Experiential Site Coordinator Responsibilities	X
Site Coordinator has been given a copy of the PATSIM Handbook	
PATSIM Site Coordinator agrees to act as a liaison between the site and the program assistant director to ensure that students receive the intended educational experience as set forth by ASHP/ACPE	
PATSIM Site Coordinator agrees to submit evaluations on each student in a timely manner	

Please list the names of anyone (pharmacists and technicians) in the pharmacy who will be assisting in the primary training of students. Please include their state Registration number. When signing this form, you are validating that each person listed has a minimum of TWO years of experience in this practice setting.

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**Signature**

**Date**

*Please note any changes that have occurred since you originally signed this form.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature NDSCS

\_\_\_\_\_  
Date