**Accreditation questionnaire for public pharmacies that are involved in the training of pharmacy students during summer practice.**

1. **The candidate pharmacy’s data:**

Name:………………………………………………………………….……………………………………………………………

Address:………………………………………………………………….…………………………………………………………

Head of pharmacy:………………………………………………………………….…………………………………………

Telephone: ……………….Fax:………………… E-mail:………………………….…………

Responsible person for training: ……………………………………………………..……………………………………………………….

Number of trained stuff:…………..pharmacist:………..…. assistant:………...

Pharmaceutical care: yes/ no

How many students can go for summer practice in the pharmacy?………………………………………………………………………………..

1. **Personal requirements, data for trainer pharmacist (if there is more trainer pharmacist in the pharmacy, everyone should fill this part)**

Name of trainer pharmacist:…………………………………………………………………………………………

Place and the date of graduation:…………………………………………………………………………………

Professional experience: ……..year

Scientific degree, date: ………………………….………………………………………………………………………

Language knowledge (language exam, date) ………………………………………………………………………………………………………………………………………….

How many pharmacy students did you train per year in the last five years?

………………………………………………………………………………………………………………………………………….

Are you a member of any pharmaceutical organization?

………………………………………………………………………………………………………………………………………….

1. **Data from the objective requirements of pharmacy**

Number of prescription / year: …………………….

Number of individual prescription you prepare in the pharmacy/ year: ………………………

Is the laboratory of pharmacy well equipped? ……………………………………………

Is there any aseptic work in the pharmacy: …………………… prescription/ year:

What is the name of computer program you use in pharmacy?

…………………………………………………………………………………………

Is there any computer data base for professional information what student can use in the pharmacy (at least 2 hours/day)? Yes /No

Is there any professional journal you have in the pharmacy?

………………………………………………………………………………………………

Is there any quality assurance system in the pharmacy? Yes /No

If yes? What is the name of the quality assurance system?

………………………………………………………………………………………………

Other comment: ……………………………………………………………………………………………………………….

I hereby declare that the above data are true and correct.

 Head of pharmacy

 Stamp of pharmacy

……………………………, ……….year …………..month………day