Pharmacy Experience Evaluation Form

Date: _____

Pharmacy Name: _____

Pharmacist Supervisor: _____

Evaluated Student Name: _____

Evaluation Period: From _____ To _____

Evaluation Criteria

Criteria	Rating (1-5)	Comments
Knowledge of Pharmacy Practice	____	_____
Communication Skills	____	_____
Professionalism	____	_____
Teamwork	____	_____
Technical Skills	____	_____

Overall Evaluation

Overall Performance Rating: _____

Final Comments: _____

Signatures

Pharmacist Supervisor: _____ Date: _____

Evaluated Student: _____ Date: _____