

**SCHEME : J**

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

Roll No. : \_\_\_\_\_ Year : 20\_\_ 20\_\_

Exam Seat No. : \_\_\_\_\_

# Practical Training Project Report



**DIPLOMA IN PHARMACY**



**MAHARASHTRA STATE BOARD OF  
TECHNICAL EDUCATION, MUMBAI**  
(Autonomous) (ISO 9001: 2015) (ISO/IEC 27001:2013)

## **VISION**

To ensure that the diploma level technical education constantly matches the latest requirements of technology and industry and includes the all-round personal development of students including social concerns and to become globally competitive, technology led organization.

## **MISSION**

To provide high quality technical and managerial manpower, information and consultancy services to the industry and community to enable the industry and community to face the challenging technological & environmental challenges.

## **QUALITY POLICY**

We, at MSBTE are committed to offer the best-in-class academic services to the students and institutes to enhance the delight of industry and society. This will be achieved through continual improvement in management practices adopted in the process of curriculum design, development, implementation, evaluation and monitoring system along with adequate faculty development programmes.

## **CORE VALUES**

**MSBTE believes in the following:**

- ✓ Skill development in line with industry requirements.
- ✓ Industry readiness and improved employability of Diploma holders.
- ✓ Synergistic relationship with industry.
- ✓ Collective and Cooperative development of all stake holders.
- ✓ Technological interventions in societal development.
- ✓ Access to uniform quality technical education.

# **PRACTICAL TRAINING PROJECT REPORT**

## **Diploma in Pharmacy (Part-III)**



**Maharashtra State Board of Technical  
Education, Mumbai.**

**(Autonomous)**

**(ISO 9001:2015) (ISO/IEC27001:2013)**

**PCI ER-2020/‘J’ Scheme Curriculum**



**Maharashtra State Board of Technical Education, Mumbai**

**(Autonomous) (ISO 9001:2015) (ISO/IEC27001:2013)**

**4th floor, Government Polytechnic Building, 49, Kherwadi, Bandra  
(E), Mumbai- 400 051  
(Printed on – July 2024)**



# MAHARASHTRA STATE BOARD OF TECHNICAL EDUCATION, MUMBAI

## CERTIFICATE

This is to certify that Mr. /Ms. \_\_\_\_\_

Roll No. \_\_\_\_\_ of Second Year Diploma in Pharmacy studying at

\_\_\_\_\_ has completed the practical training (Part-III) from \_\_\_\_\_ to \_\_\_\_\_

for the academic year 20 - 20 as prescribed in the PCI ER 2020 syllabus.

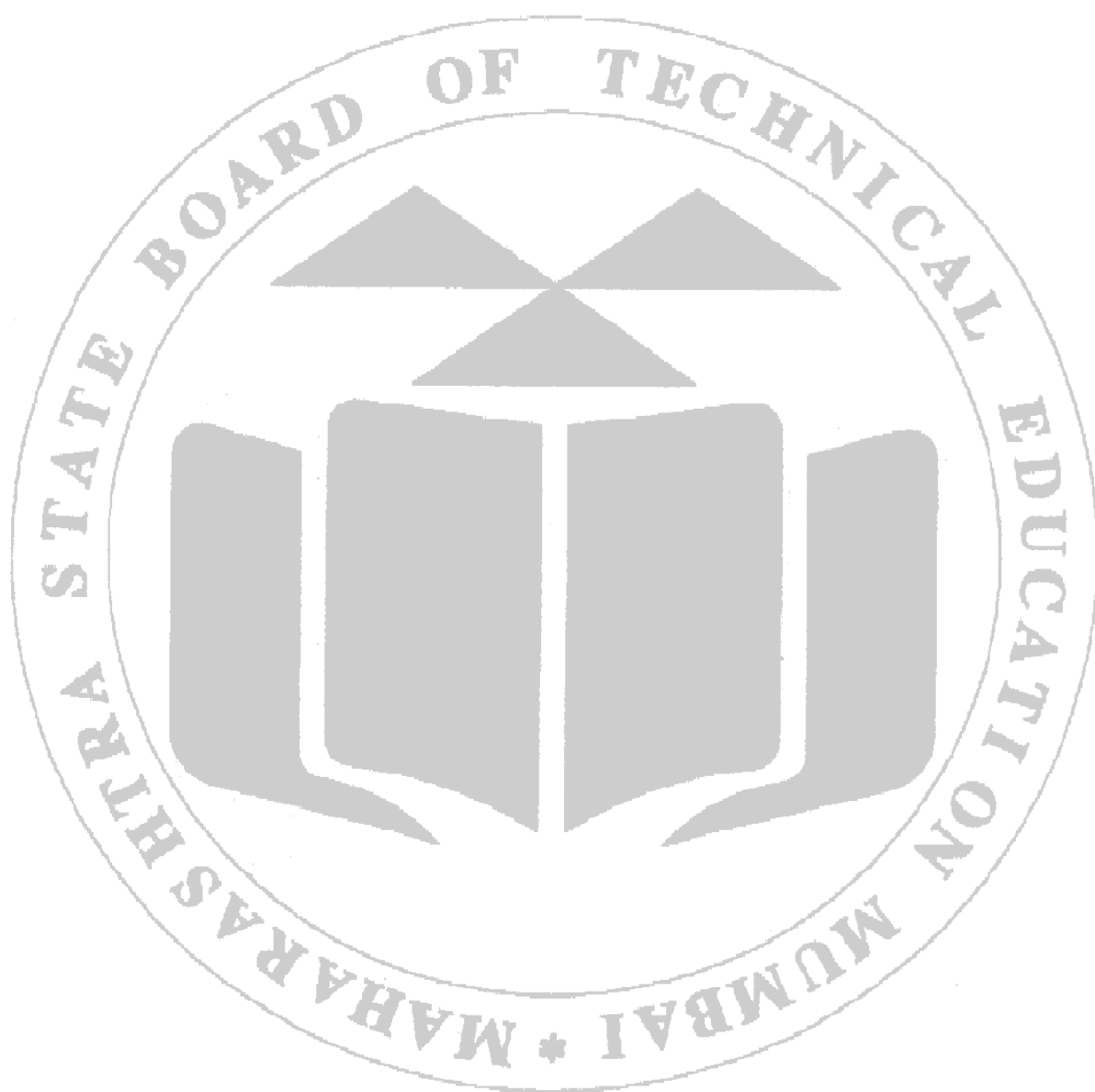
Date: \_\_\_\_\_ Enrollment No.: \_\_\_\_\_

Place: \_\_\_\_\_ Exam Seat No.: \_\_\_\_\_

**Project Guide**

**Principal**

Seal of the Institute



## PROGRAM OUTCOMES

1. **Pharmacy knowledge:** Possess knowledge and comprehension of the core and basic knowledge associated with the profession of pharmacy.
2. **Modern tool usage:** Learn, select, and apply appropriate methods and procedures, resources, and modern pharmacy-related computing tools with an understanding of the limitations.
3. **Leadership skills:** Understand and consider the human reaction to change, motivation issues, leadership, and team-building when planning changes required for fulfilment of practice, professional and societal responsibilities. Assume participatory roles as responsible citizens or leadership roles when appropriate to facilitate improvement in health and wellbeing.
4. **Professional identity:** Understand, analyse, and communicate the value of their professional roles in society (e.g. health care professionals, promoters of health, educators, managers, employers, employees).
5. **Pharmaceutical ethics:** Honour personal values and apply ethical principles in professional and social contexts. Demonstrate behaviour that recognizes cultural and personal variability in values, communication, and lifestyles. Use ethical frameworks; apply ethical principles while making decisions and take responsibility for the outcomes associated with the decisions.
6. **Communication:** Communicate effectively with the pharmacy community and with society at large, such as being able to comprehend and write effective reports, make effective presentations and documentation, and give and receive clear instructions.
7. **The Pharmacist and society:** Apply reasoning informed by contextual knowledge to assess societal, health, safety, and legal issues and the consequent responsibilities relevant to the professional pharmacy practice.
8. **Environment and sustainability:** Understand the impact of professional pharmacy solutions in societal and environmental contexts, and demonstrate the knowledge of, and need for sustainable development.
9. **Life-long learning:** Recognize the need for and have the preparation and ability to engage in independent and life-long learning in the broadest context of technological change. Self-assess and use feedback effectively from others to identify learning needs and satisfy these needs on an ongoing basis.

## COMPETENCIES FOR THE INDIAN D. PHARM HOLDERS

Competency is defined as “A distinct composite of knowledge, skill, attitude, and value that is essential to the practice of the profession in real-life contexts”.

The candidates who successfully complete the Diploma in Pharmacy (D. Pharm) program of Education Regulations 2020 (ER-2020), from the institutions approved by the Pharmacy Council of India are expected to attain the following professional competencies.

- 1. Review Prescriptions:** The student should receive and handle prescriptions professionally and be able to check for their completeness and correctness. Also, the prescribers should be contacted for any clarifications & corrections in the prescriptions with suggestions if any.
- 2. Dispense Prescription / Non-Prescription Medicines:** The student should be able to dispense the various scheduled drugs/medicines as per the implications of the Drug & Cosmetic Act and the Rules thereunder. Also, non-prescription medicines (over-the-counter drugs) should be dispensed judiciously to the patients as required.
- 3. Provide Patient Counseling/Education:** The student should be able to effectively counsel/educate the patients/caretakers about prescription/non-prescription medicines and other health-related issues. Effective communication includes using both oral and written communication skills and various communication techniques.
- 4. Hospital and Community Pharmacy Management:** The student be able to manage the drug distribution system as per the policies and guidelines of the hospital pharmacy, good community pharmacy practice, and the recommendations of regulatory agencies. Also, be able to manage the procurement, inventory, and distribution of medicines in hospital/community pharmacy settings.
- 5. Expertise on Medications:** The student should be able to provide an expert opinion on medications to healthcare professionals on safe and effective medication – use, relevant policies, and procedures based on available evidence.
- 6. Proficiency on Pharmaceutical Formulations:** The student should be able to describe the chemistry, characteristics, types, merits, and demerits of both drugs and excipients used in pharmaceutical formulations based on her/his knowledge and scientific resources.
- 7. Entrepreneurship and Leadership:** The student should be able to acquire entrepreneurial skills in dynamic professional environments. Also, be able to achieve leadership skills through teamwork and sound decision-making skills.
- 8. Deliver Primary and Preventive Healthcare:** The student should be able to contribute to various healthcare programs of the nation including disease prevention initiatives to improve public health. Also, contribute to the promotion of national health policies.
- 9. Professional, Ethical, and Legal Practice:** The student should be able to deliver professional services in accordance with legal, ethical, and professional guidelines with integrity.
- 10. Continuing Professional Development:** The student should be able to recognize the gaps in the knowledge and skills in the effective delivery of professional services from time to time and be self-motivated to bridge such gaps by attending continuing professional development programs.



## COMPETENCY MAPPING WITH THE COURSE

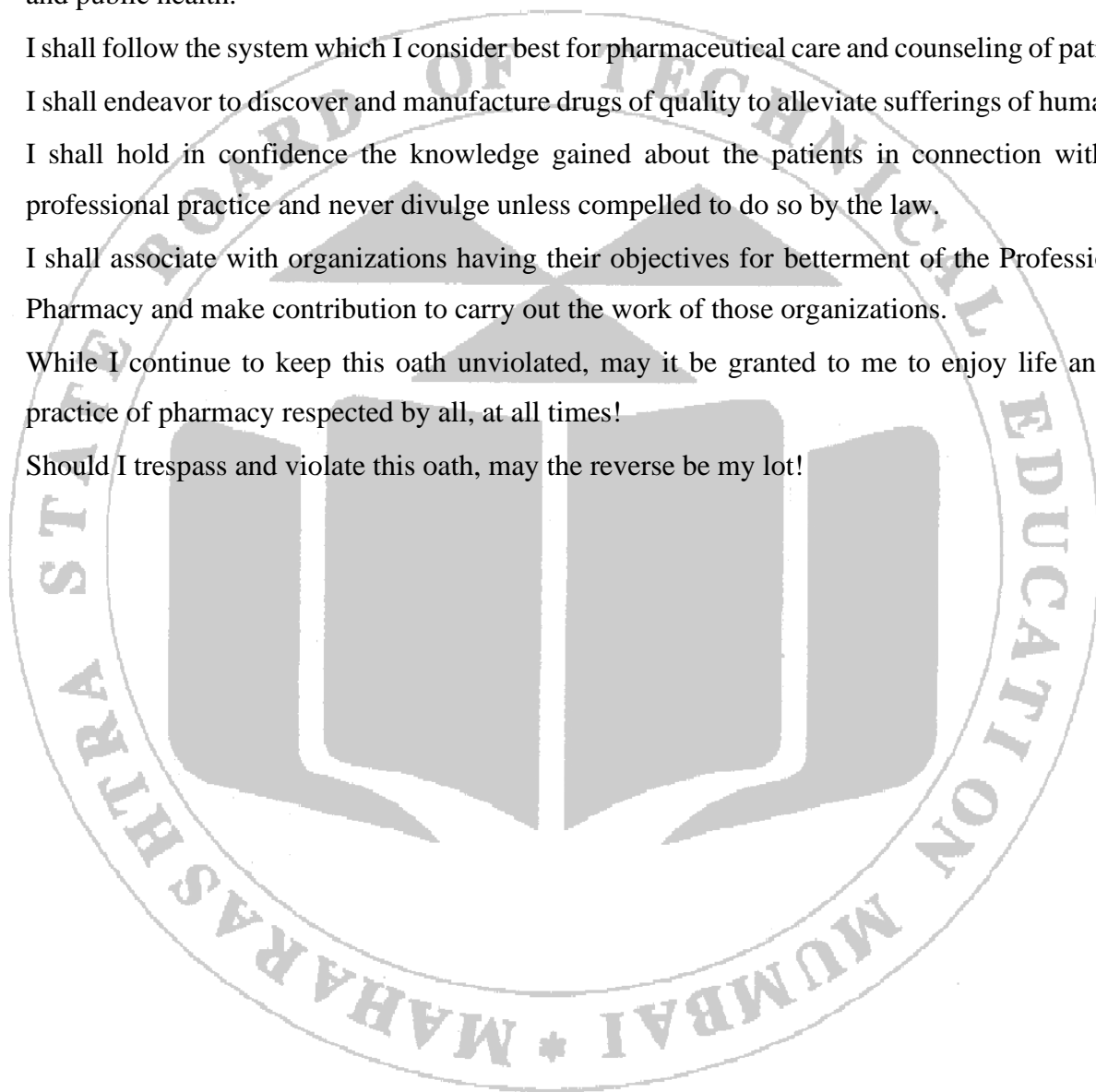
Competencies	Practical Training
1. Review Prescriptions	✓
2. Dispense Prescription / Non-Prescription Medicines	✓
3. Provide Patient Counseling / Education	✓
4. Hospital and Community Pharmacy Management	✓
5. Expertise on Medications	✓
6. Proficiency on Pharmaceutical Formulations	✓
7. Entrepreneurship and Leadership	✓
8. Deliver Primary and Preventive Healthcare	✓
9. Professional, Ethical, and Legal Practice	✓
10. Continuing Professional Development	✓

**PRACTICAL TRAINING PROJECT REPORT****INDEX**

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## PHARMACISTS OATH

- I swear by the code of Ethics of Pharmacy council of India in relation with the community and shall acts as an integral part of health care team.
- I shall uphold the laws and standards governing my profession.
- I shall strive to perfect and enlarge my knowledge to contribute to the advancement of pharmacy and public health.
- I shall follow the system which I consider best for pharmaceutical care and counseling of patients.
- I shall endeavor to discover and manufacture drugs of quality to alleviate sufferings of humanity.
- I shall hold in confidence the knowledge gained about the patients in connection with my professional practice and never divulge unless compelled to do so by the law.
- I shall associate with organizations having their objectives for betterment of the Profession of Pharmacy and make contribution to carry out the work of those organizations.
- While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of pharmacy respected by all, at all times!
- Should I trespass and violate this oath, may the reverse be my lot!



## INTRODUCTION TO PRACTICAL TRAINING (PART-III)

### Practical Training:

The goal of practical training for the students is to provide real-time, supervised experience on the professional tasks emphasized in their course of study. Furthermore, it helps them apply their acquired knowledge and skills in a professional working environment. The practical training intensively prepares the students with adequate competencies and qualifications required for future career opportunities.

Practical Training is designed to teach candidates the basic concepts of pharmaceutical sciences, including:

- Safe and accurate processing of prescriptions
- Dispensing of medicines
- Proper storage of drug, and record-keeping as required under the D & C Act
- Narcotic drug handling
- Purchasing, merchandising, and inventory control
- Pharmaceutical laws regulating the profession of pharmacy.
- Display of licenses such as Pharmacist Registration Licenses, Drug Licenses, FSSAI License, etc.
- Computer processing (handling of pharmacy billing software)
- Patient counseling

After completing practical training, students will be able to:

- Demonstrate knowledge of pharmacy practice and the ability to acquire, manage, and use current information for problem-solving, patient-specific, population-specific, evidence-based care to promote safe and optimal pharmacotherapy outcomes.
- Create awareness in society about the effective and safe use of medicines.
- Identify the rules and regulations involved in the distribution, sale, and safe use of medicines and participate in the development of drug use policy.
- Imbibe ethical practices and moral values in personal and professional endeavors.
- Communicate effectively with the pharmacy community and society at large.

### Period and other conditions for practical training-

1. After having appeared in Part-II examination for the Diploma in Pharmacy held by an approved Examining Authority a candidate shall be eligible to undergo practical training in one or more of the following institutions namely:
  - a. Hospitals/Dispensaries run by Central /State Governments.
  - b. A pharmacy licensed for retail sale of drugs under the Drugs and Cosmetics Rules, 1945 having the services of registered pharmacists.

- c. Hospitals and Dispensaries other than those specified (a) above to give practical training shall have to be recognized by the Pharmacy Council of India.
2. The institutions referred in (1) shall be eligible to impart training subject to the condition that a number of student pharmacists that may be taken in any hospital, dispensary, or pharmacy licensed under the Drugs and Cosmetics Rules, 1945 made under the Drugs and Cosmetics Act, 1940, shall not exceed four where there is one registered pharmacist engaged in the work in which the student pharmacist is undergoing practical training, where there is more than one registered pharmacist similarly engaged, the number shall not exceed two for each additional such registered pharmacist.
3. In the course of practical training, the trainee shall have exposure to –
  - a. Working knowledge of keeping records required by various Legislative Acts concerning the profession of pharmacy; and
  - b. Practical experience in activities as follows:
    - i. Stocking of Drugs and Medical Devices
    - ii. Inventory Control Procedures
    - iii. Handling of prescriptions
    - iv. Dispensing (250 hours)
    - v. Patient counseling.
4. The practical training shall be not less than five hundred hours spread over a period of not less than three months provided that not less than two hundred and fifty hours are devoted to the actual dispensing of prescriptions.

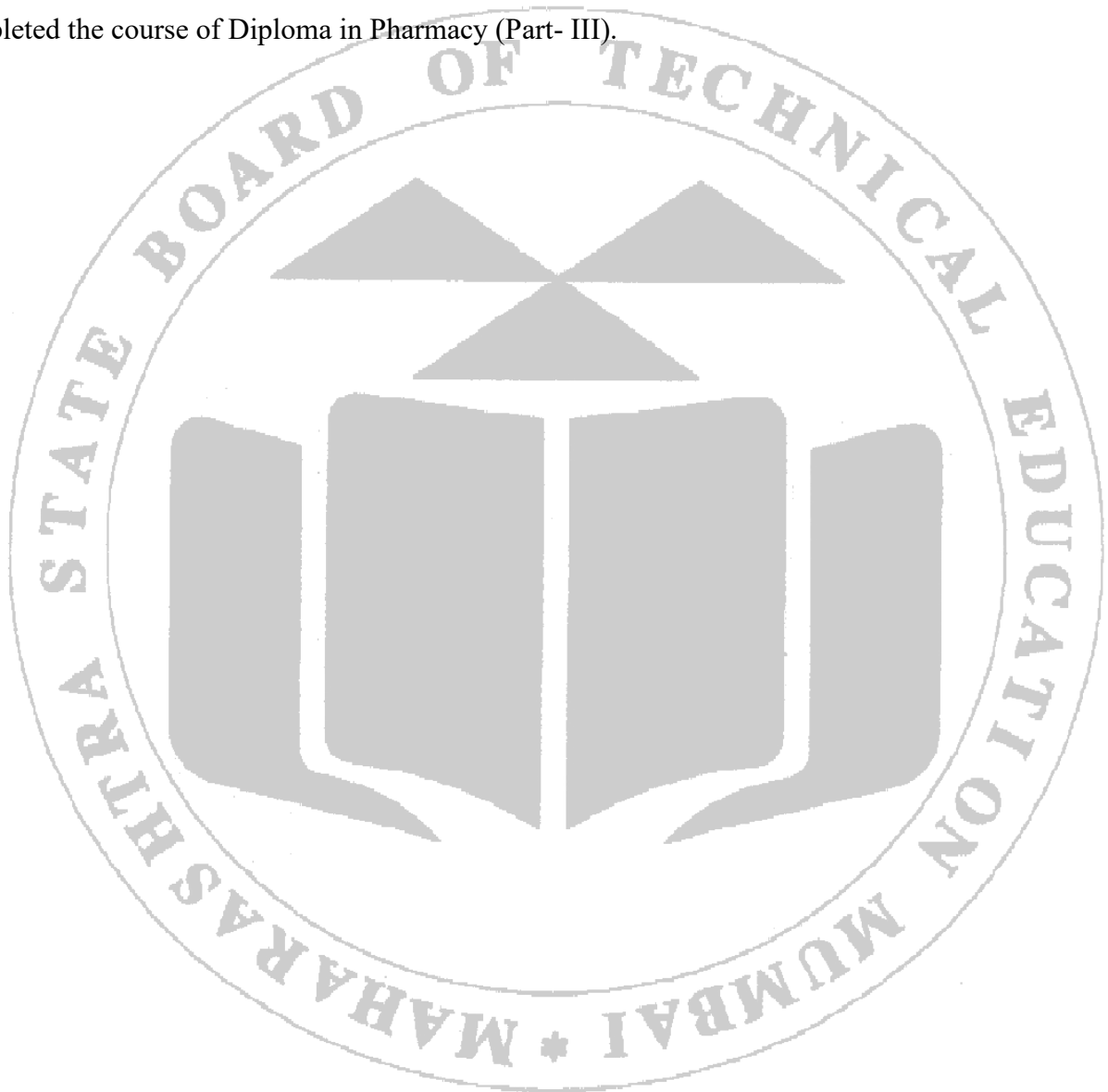
**Procedure to be followed before to commencement of the training-**

1. The head of the institution imparting practical training, on application, shall supply in triplicate 'Practical Training Contract Form for Pharmacist' (hereinafter referred to as the Contract Form) to the candidate eligible to undertake the said practical training.
2. The head of the institution imparting practical training shall fill Section I of the Contract Form. The trainee shall fill Section II of the said Contract Form and the head of the institution agreeing to impart the training (hereinafter referred to as the Apprentice Master) shall fill Section III of the said Contract form.
3. It shall be the responsibility of the trainee to ensure that one copy (hereinafter referred to as the first copy of the Contract Form) so filled is submitted to the head of the institution imparting practical training and the other two copies (hereinafter referred to as the second copy and the third copy) shall be filed with the Apprentice Master (if he so desires) or with the trainee till completion of the training.

**Certificate of passing Diploma in Pharmacy Part-III**

On satisfactory completion of the practical training period the Apprentice Master shall fill Section IV of the second copy and third copy of the Contract Form and forward it to the head of institution imparting practical training who shall suitably enter in the first copy of the entries from the second copy and the third copy and shall fill Section V of the three copies of Contract Form and thereafter hand over both the second copy and the third copy to the trainee.

This Contract Form, completed in all respects, shall be regarded as a certificate of having successfully completed the course of Diploma in Pharmacy (Part- III).



## PATIENT COUNSELING AND COMMUNICATION

Patient counseling and communication are essential parts of the profession of a pharmacist working in a drug store. The trainee pharmacist must focus on the counseling procedure and address patients' queries.

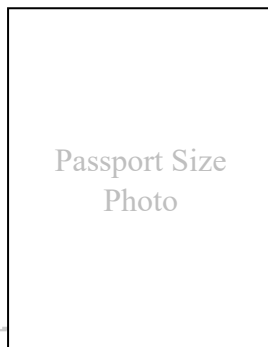
- Begin the conversation by inquiring about the patient's age, any prior treatment, and any allergies they may have, and record this information.
- Inform the patient about the name of the medication, its dose, and storage instructions. Confirm understanding by asking a few more questions.
- Explain the importance of the treatment, especially if it is an antibiotic, and why completing the full course is necessary.
- Provide information about side effects, drug interactions (if multiple drugs are prescribed), drug-food interactions, and ways to avoid them.
- Advise the patient about minor side effects and precautions. For major side effects, advise them to see a doctor immediately.
- If a dose is missed, instruct them to skip the missed dose and not to take two doses together (missed dose + regular dose).
- Provide simple pamphlets with information on storage and administration procedures, depicted with simple pictures.
- Provide information about the administration of the drug:
  - Do not take on an empty stomach or with milk/food.
  - Do not swallow or chew tablets meant to be dissolved (e.g., lozenges).
  - Shake well before use in the case of liquids.
  - Follow the dosage schedule as prescribed.
  - Do not use the bottle lid to measure liquid medicine.
- Provide information about the proper and safe use of medicine.
  - Give proper directions for the use of the drug:
  - In the case of eye drops, explain how to apply them using the dropper.
  - Specify the duration of the course for which the drug should be taken.
- Provide information about the storage of the medicine:
  - Store it in a cool, dry, and dark place.
  - Discard expired medicine.
  - Close the lid of the bottle properly.
  - Keep the medicine out of reach of children.

## TIPS FOR EFFICIENT DISPENSING FOR PHARMACISTS

- Upon receiving a prescription, verify its legality, validity, appropriateness, and safety.
- Handle only one prescription at a time to avoid errors.
- Check expiry dates and prioritize using older stock first.
- Thoroughly check and, if possible, recheck the medicines for correct identity, strength, and dosage form.
- Ensure you are selecting the correct medicine from the shelf.
- Never dispense medications prescribed on an informal note or without the prescriber's signature.
- Communicate the proper usage of the medication to the patient:
  - Provide verbal instructions.
  - Use symbols for instructions in case the patient is illiterate.
  - Use auxiliary labels if needed. For patients who are illiterate or only understand the regional language, create a system of color-coded labels/stickers on packages to help them identify the products easily.
  - If necessary, write detailed instructions for drug administration on these labels/stickers.
- Prepare a detailed cash memo/bill for the patient, including the patient's and doctor's names and addresses, the names of the medicines, batch numbers, expiry dates, manufacturer names, and prices. The pharmacist should sign and date the receipt.
- The person preparing the bill should ensure the correct medicines are being dispensed.
- Educate patients on the importance of their therapy.
- Provide patient information leaflets with specific medications or for particular illnesses.
- Give warnings and precautions if necessary.



## STUDENT DETAILS



Name of the Student: \_\_\_\_\_

Enrolment No.: \_\_\_\_\_

Roll No.: \_\_\_\_\_

Exam Seat Numbers for **First year:** \_\_\_\_\_

**Second year:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mobile Number: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pin Code: \_\_\_\_\_

E-mail ID: \_\_\_\_\_

Practical Training Period Starts From Date \_\_\_\_\_

To Date \_\_\_\_\_

Signature of the Student

## APPRENTICE MASTER DETAILS

Name of Apprentice Master: \_\_\_\_\_

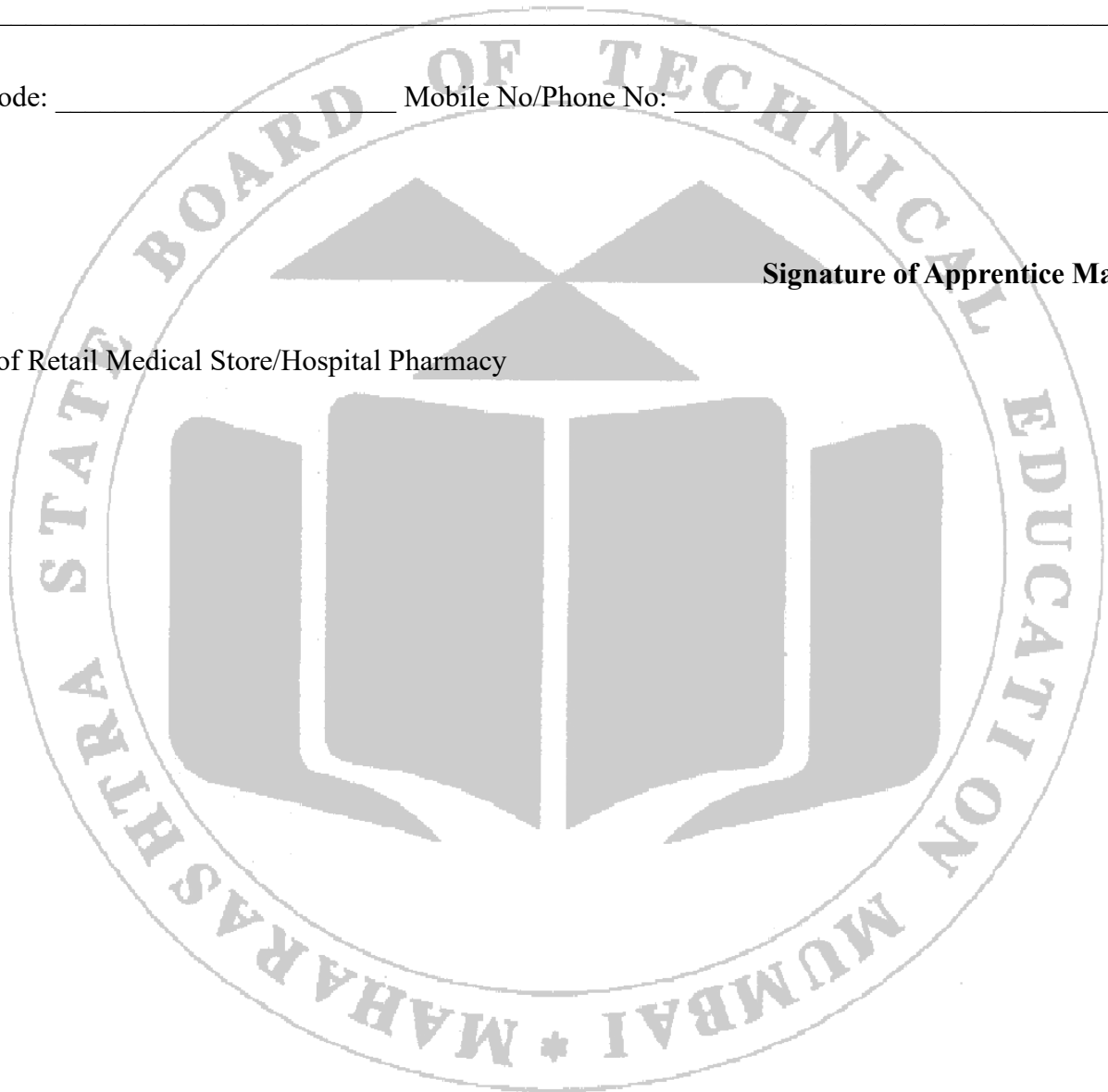
Qualification: \_\_\_\_\_ Experience: \_\_\_\_\_ years Pharmacists Registration No: \_\_\_\_\_

Name and Address of Retail Medical Store/Hospital Pharmacy: \_\_\_\_\_

Pin code: \_\_\_\_\_ Mobile No/Phone No: \_\_\_\_\_

**Signature of Apprentice Master**

Seal of Retail Medical Store/Hospital Pharmacy



## MEDICAL STORE INTRODUCTION

Name of the Medical Store: \_\_\_\_\_

Address: \_\_\_\_\_

Pin: \_\_\_\_\_

### Licenses Displayed:

#### List all licenses displayed in store:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### Nearby Physicians (within 200 meters)

#### List the names and addresses of physicians practicing near the pharmacy/medical store

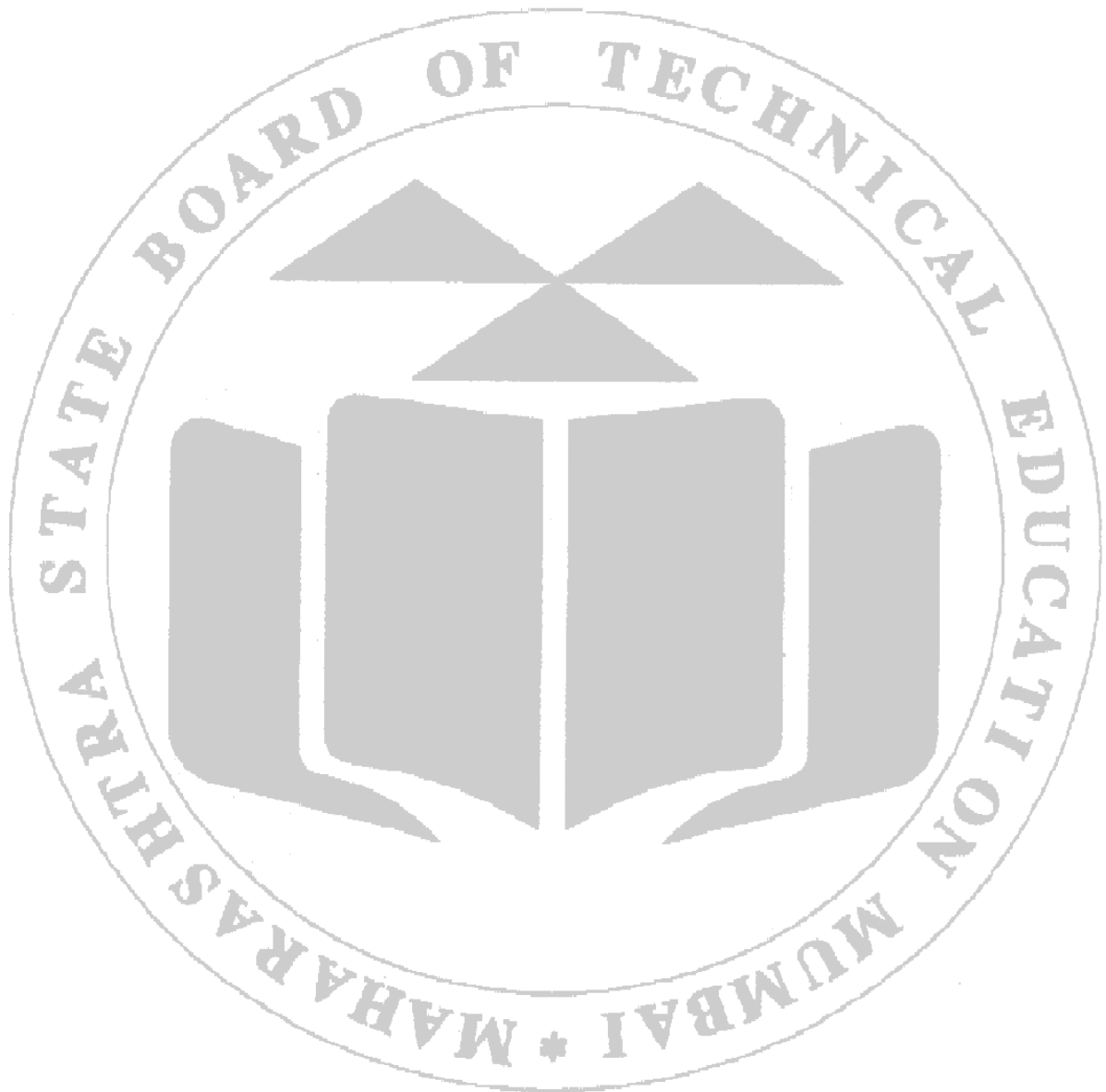
1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### Nearby Pharmacies/Medical Stores (within 500 meters)

#### List the names and addresses of pharmacies/medical stores near the one you're training in

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## LAYOUT PLAN OF MEDICAL STORE



**Daily Routine Report (Schedule and Work) in Pharmacy/Medical Store/Hospital  
Pharmacy**

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Signature of the Student

Signature of Apprentice Master

**WEEK 1 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

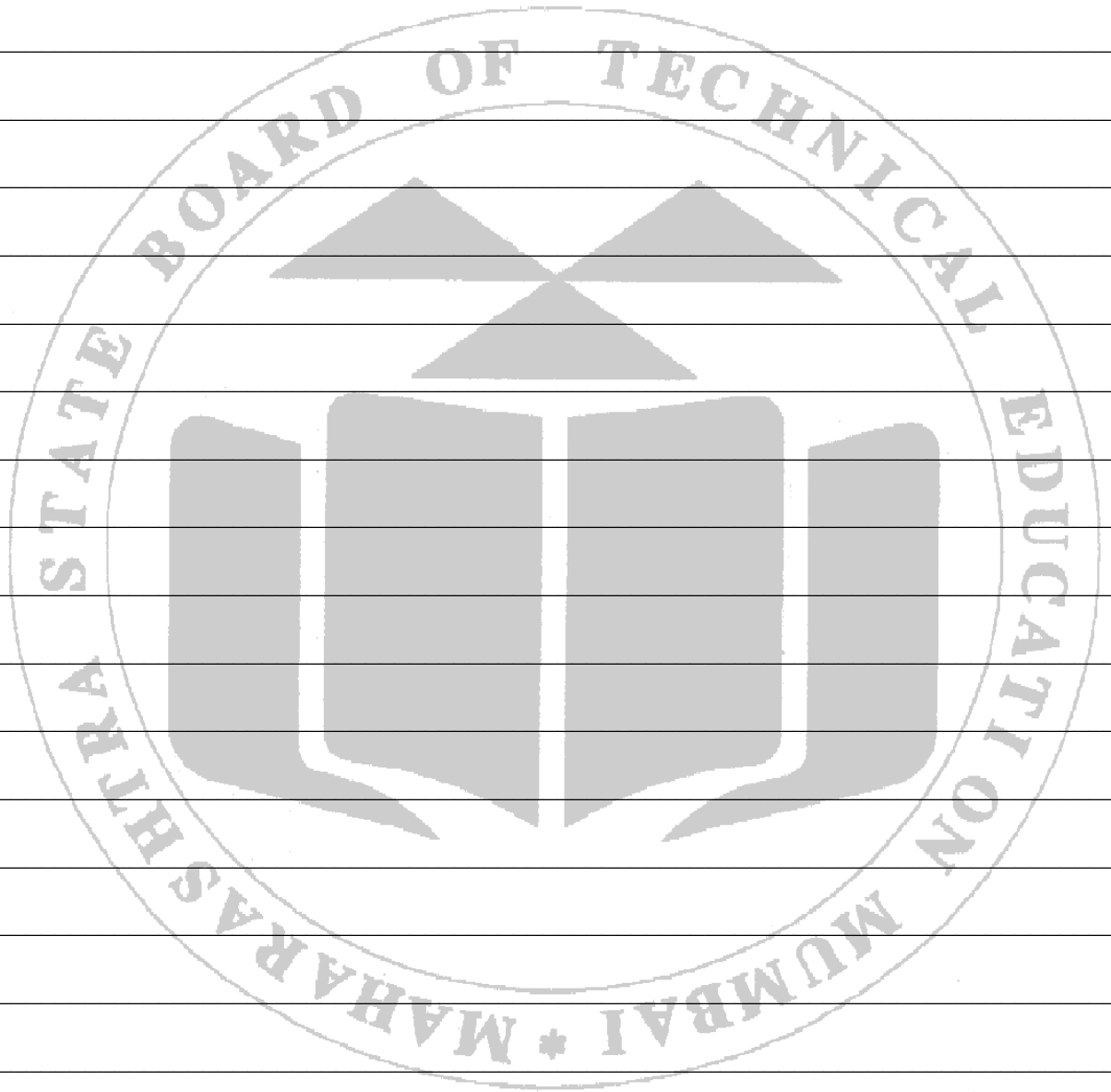
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on Patient Registration and Prescription Handling**



**WEEK 2 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

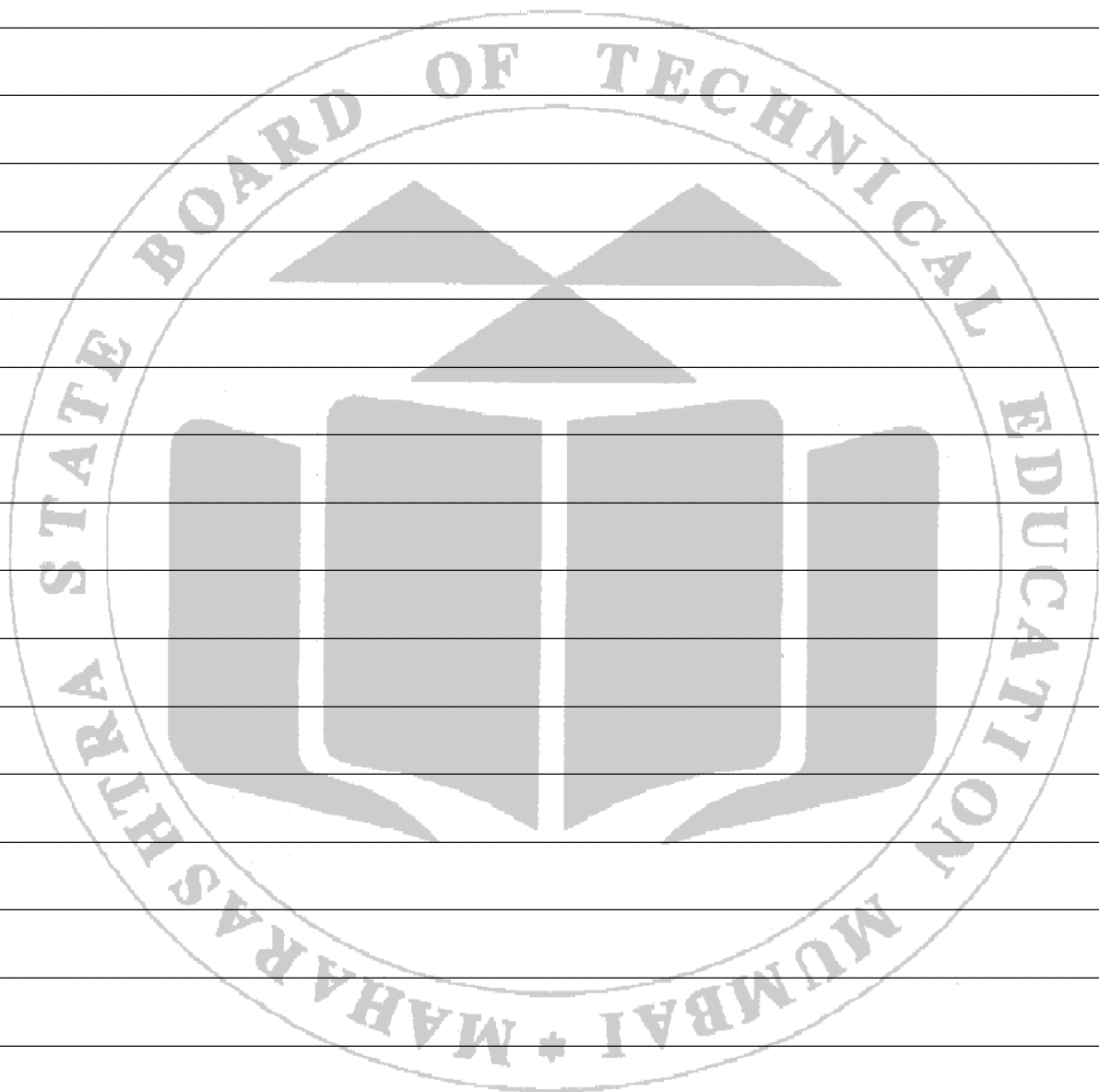
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on Experiences of Handling Prescriptions**  
**(With Respect to Adverse Drug Reactions and Drug Interactions)**



**WEEK 3 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

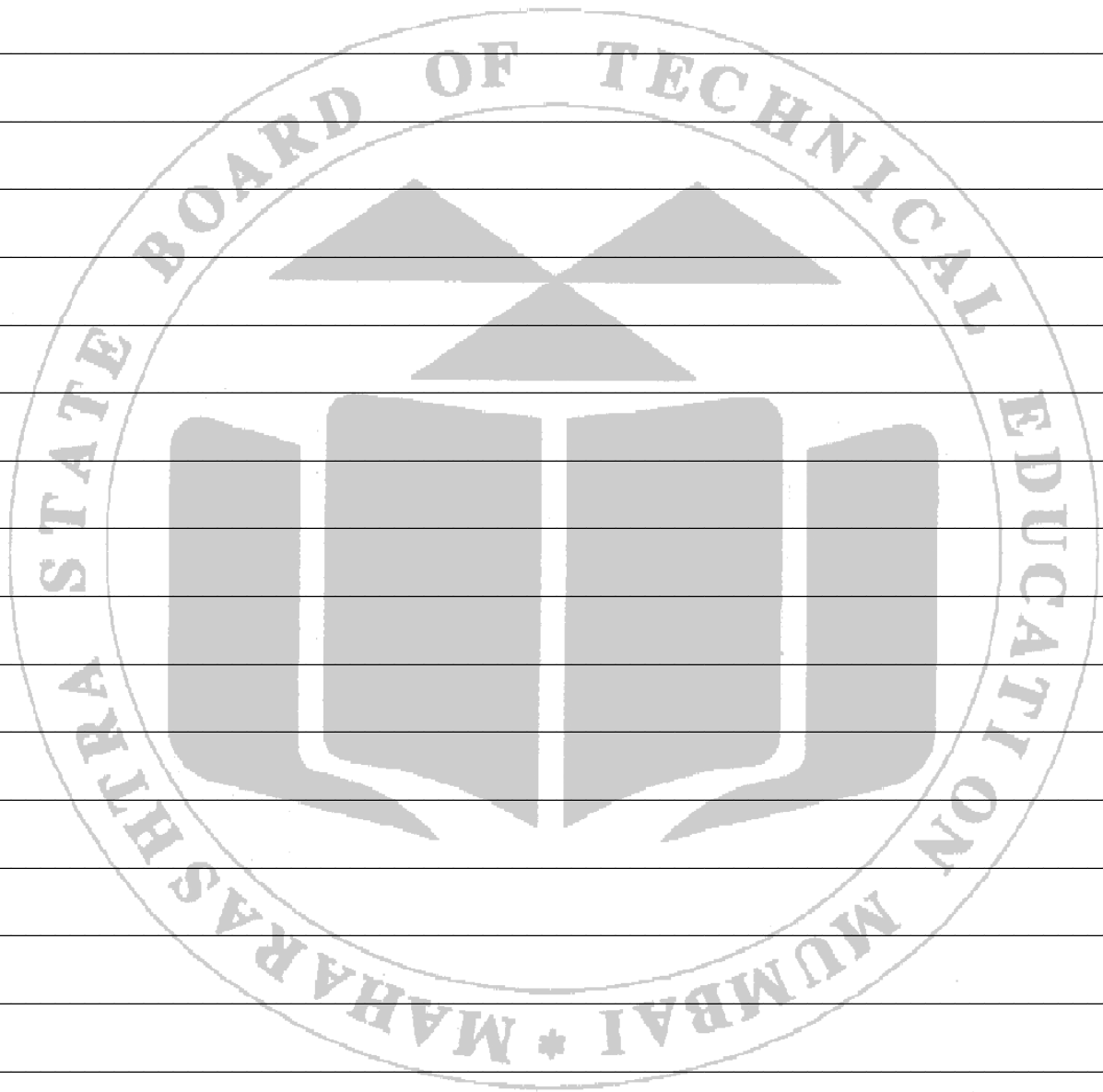
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report On Experiences During The Sale Of Over-The-Counter (OTC) Products**



**WEEK 4 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

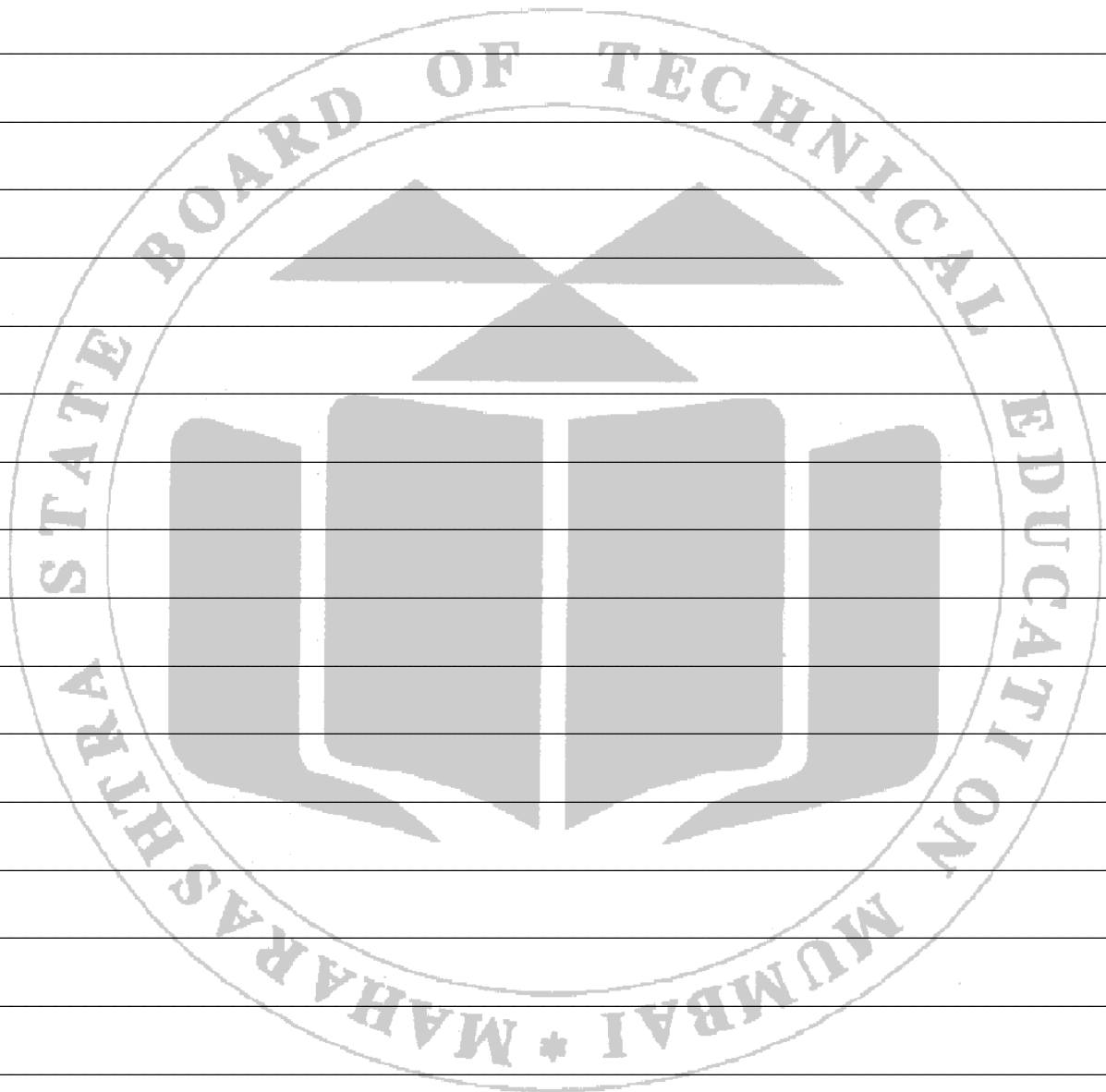
Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



**Report on Experiences in Patient Counseling During Prescription Handling**



**WEEK 5 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

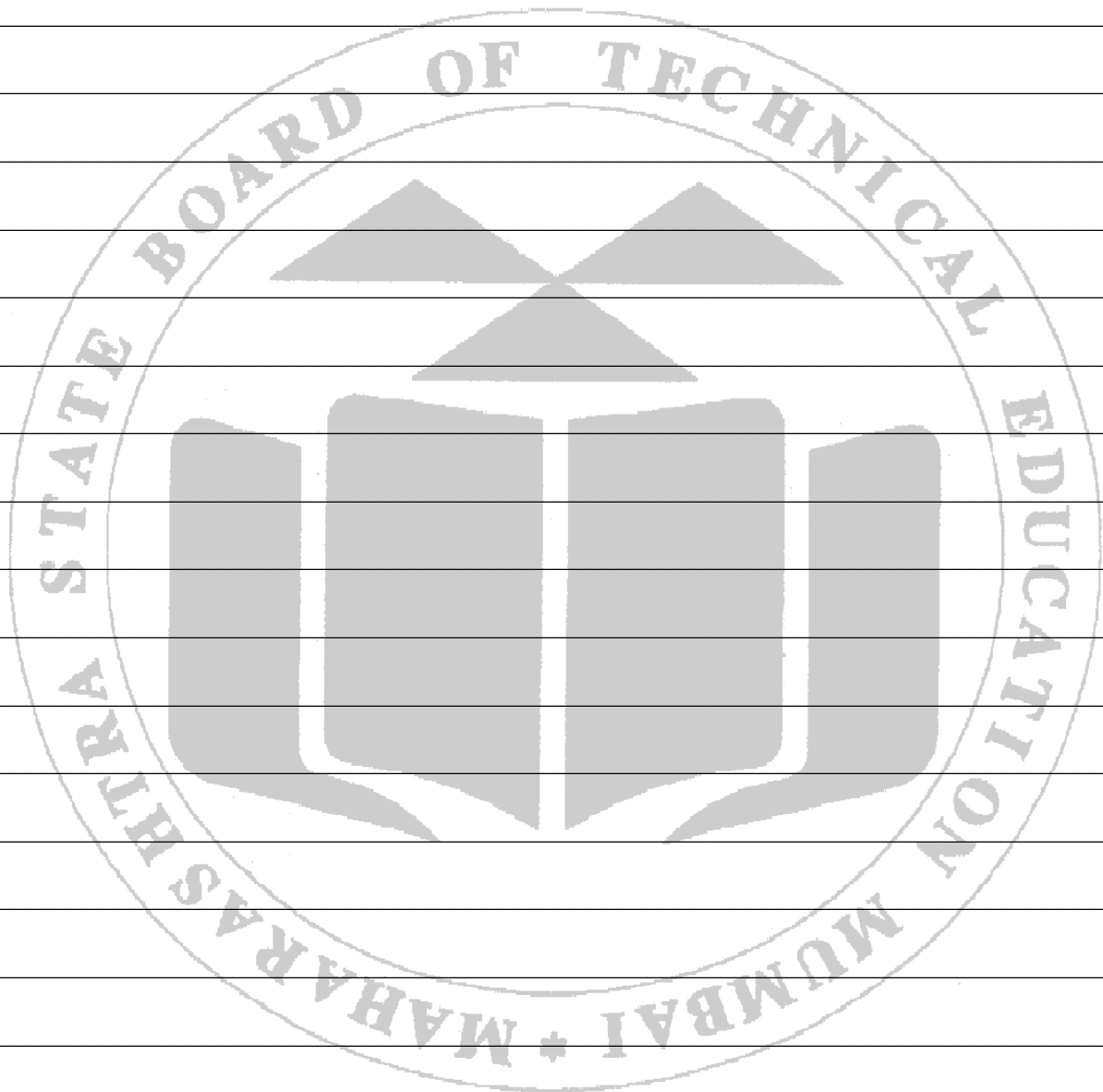
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on the Storage and Handling of Narcotic and Psychotropic Drugs**





**WEEK 6 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

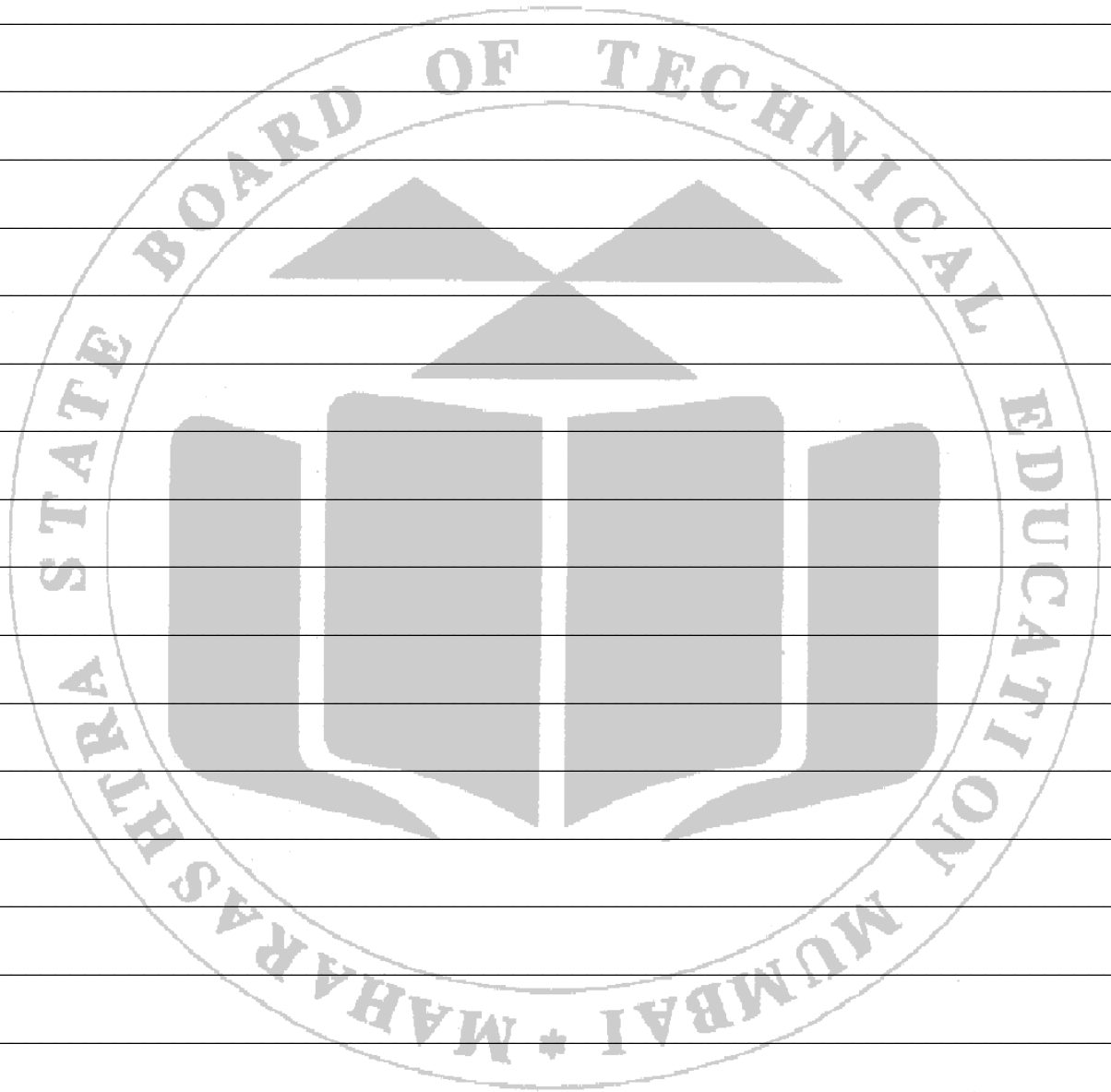
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on the Handling and Disposal of Expired Drugs/Medications**



**WEEK 7 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master



## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

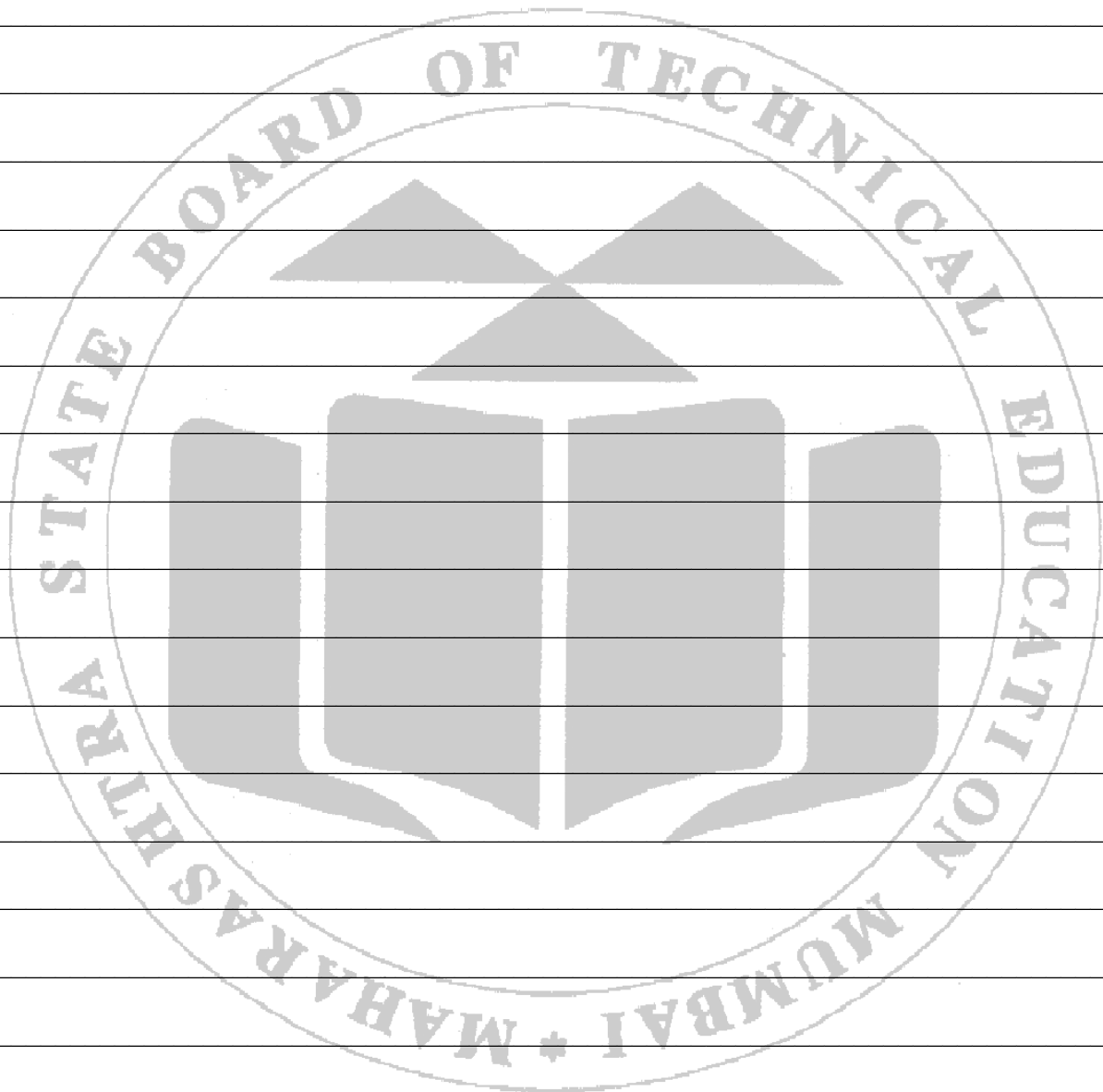
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on Experiences of Finding Substitutes for Prescribed Drugs**



**WEEK 8 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

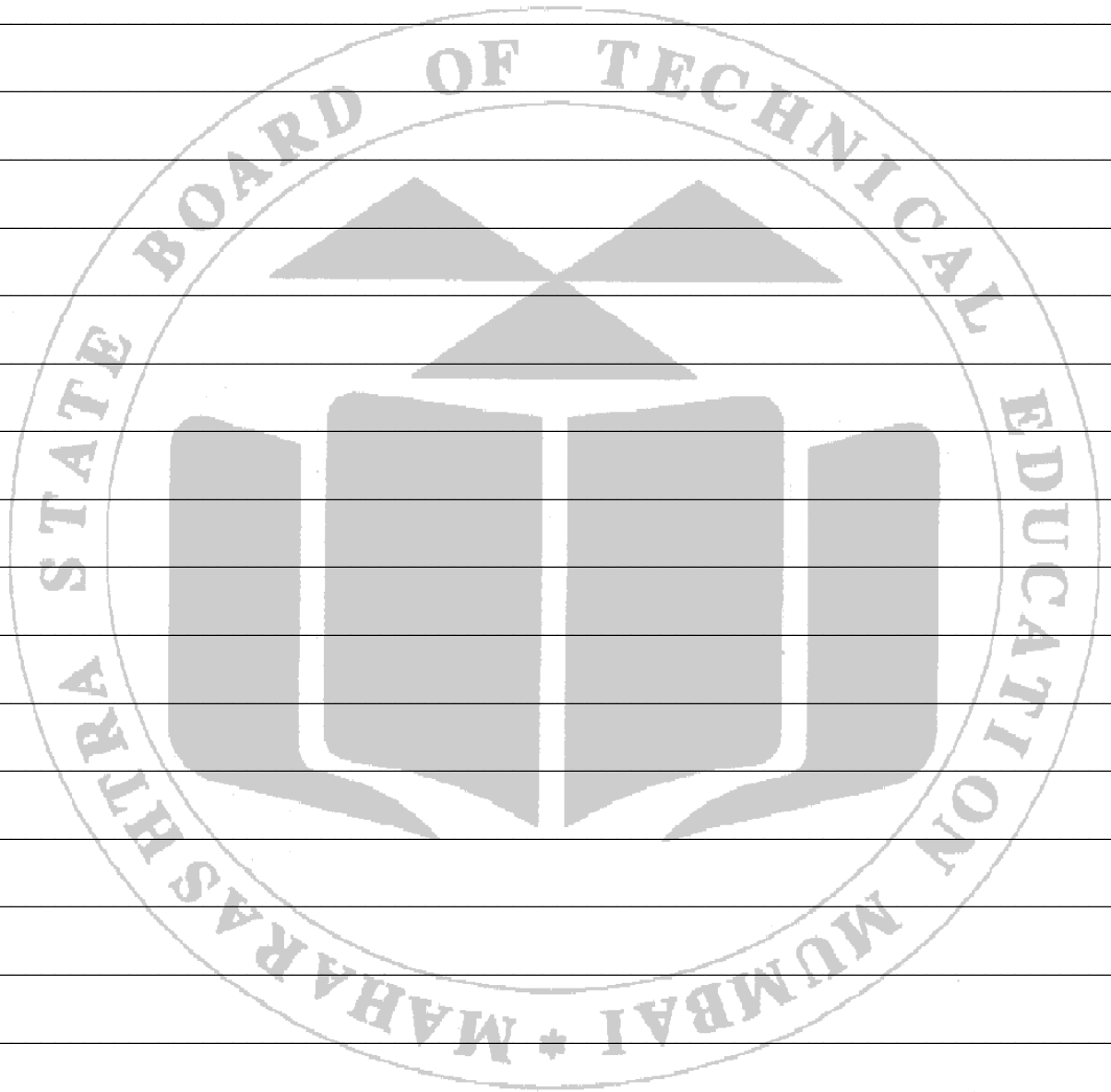
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on Drugs Sold Under Schedule G, Schedule H, and Schedule X**



**WEEK 9 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

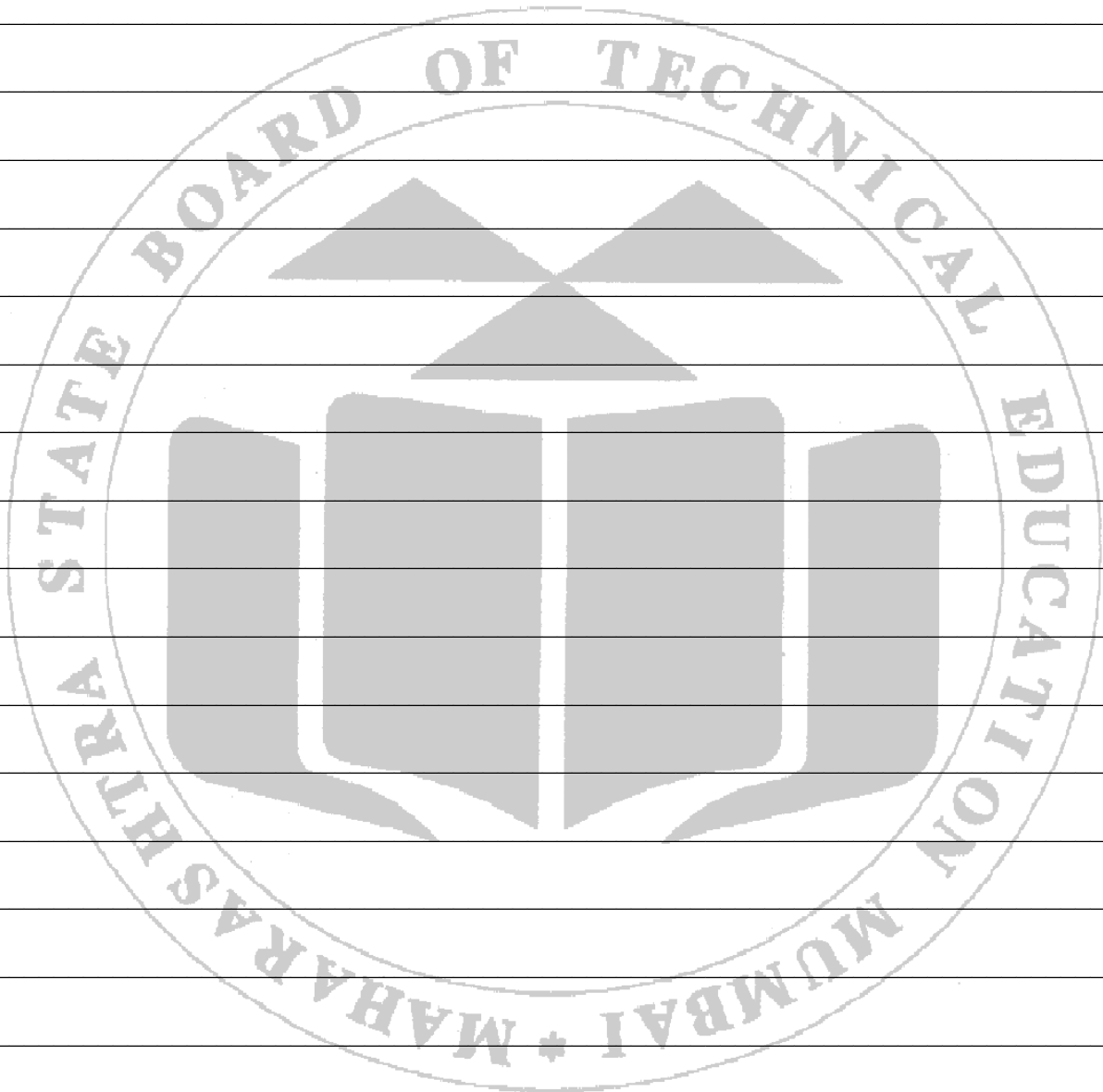
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on the Procurement and Inventory Management of Medicines and the  
Inspection Upon Their Arrival in the Store**



**WEEK 10 REPORT**

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

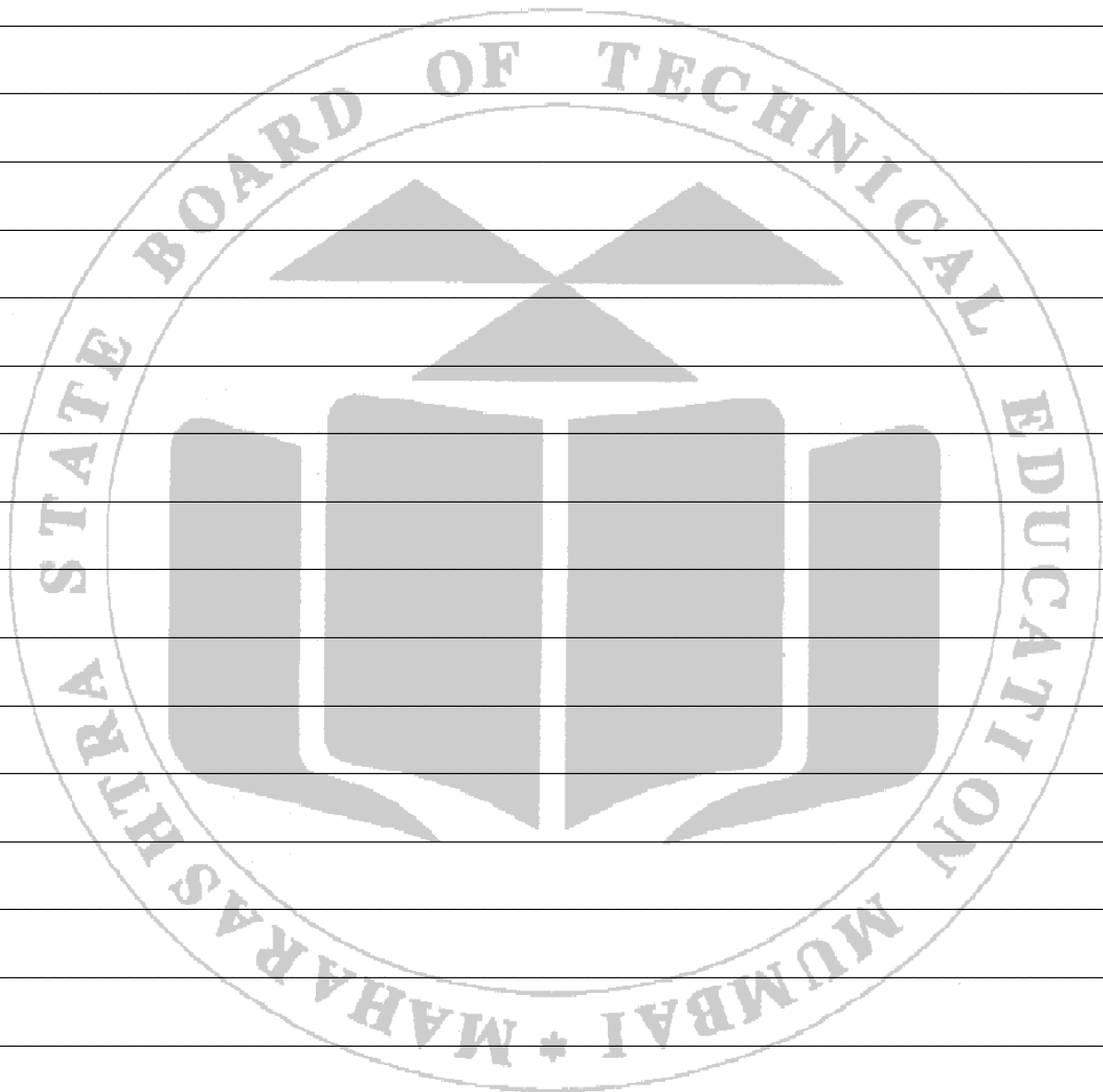
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on the Use of Computer Software in the Pharmacy Store**



## WEEK 11 REPORT

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

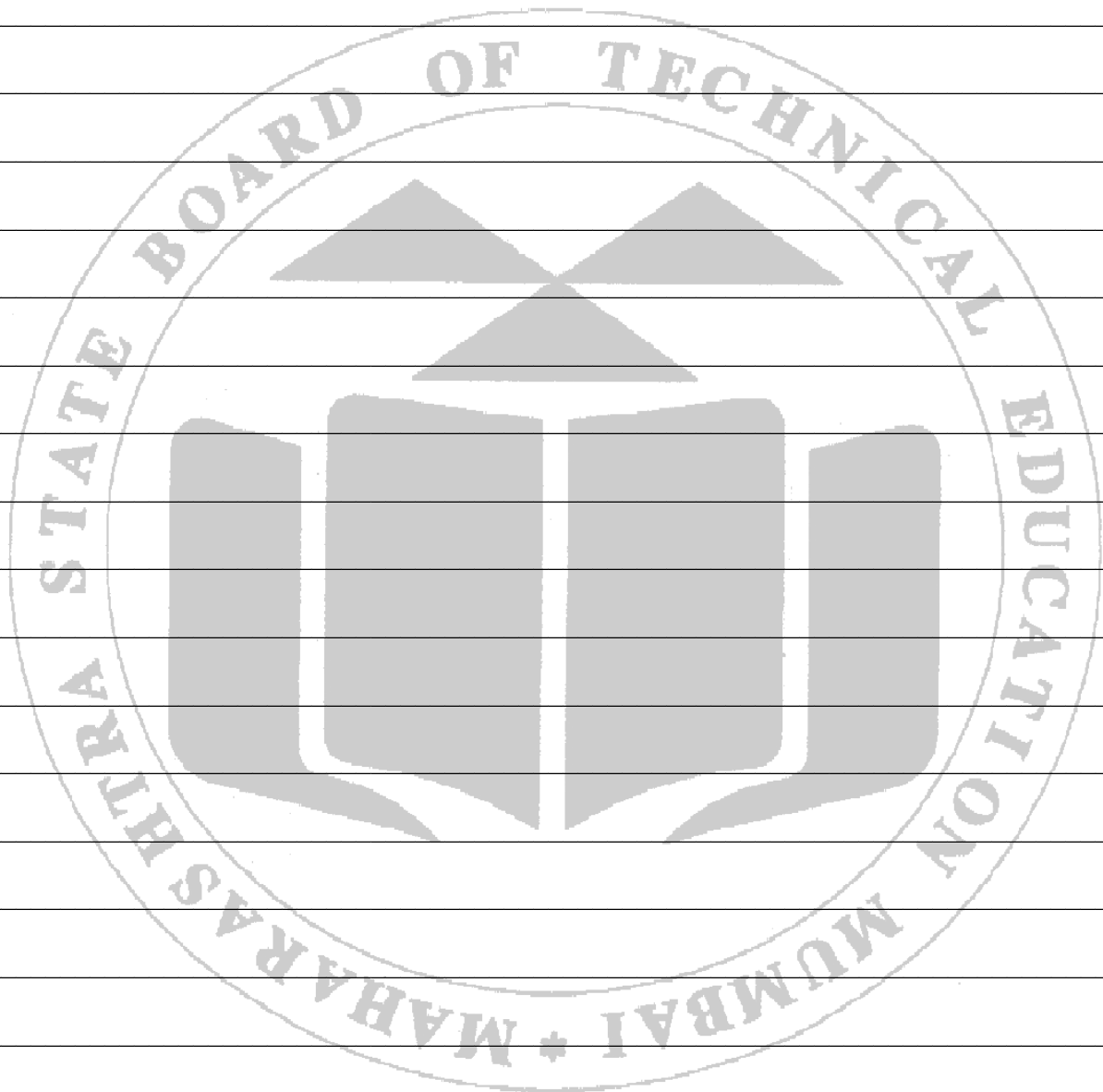
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on the Storage and Distribution of Medications**



## WEEK 12 REPORT

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

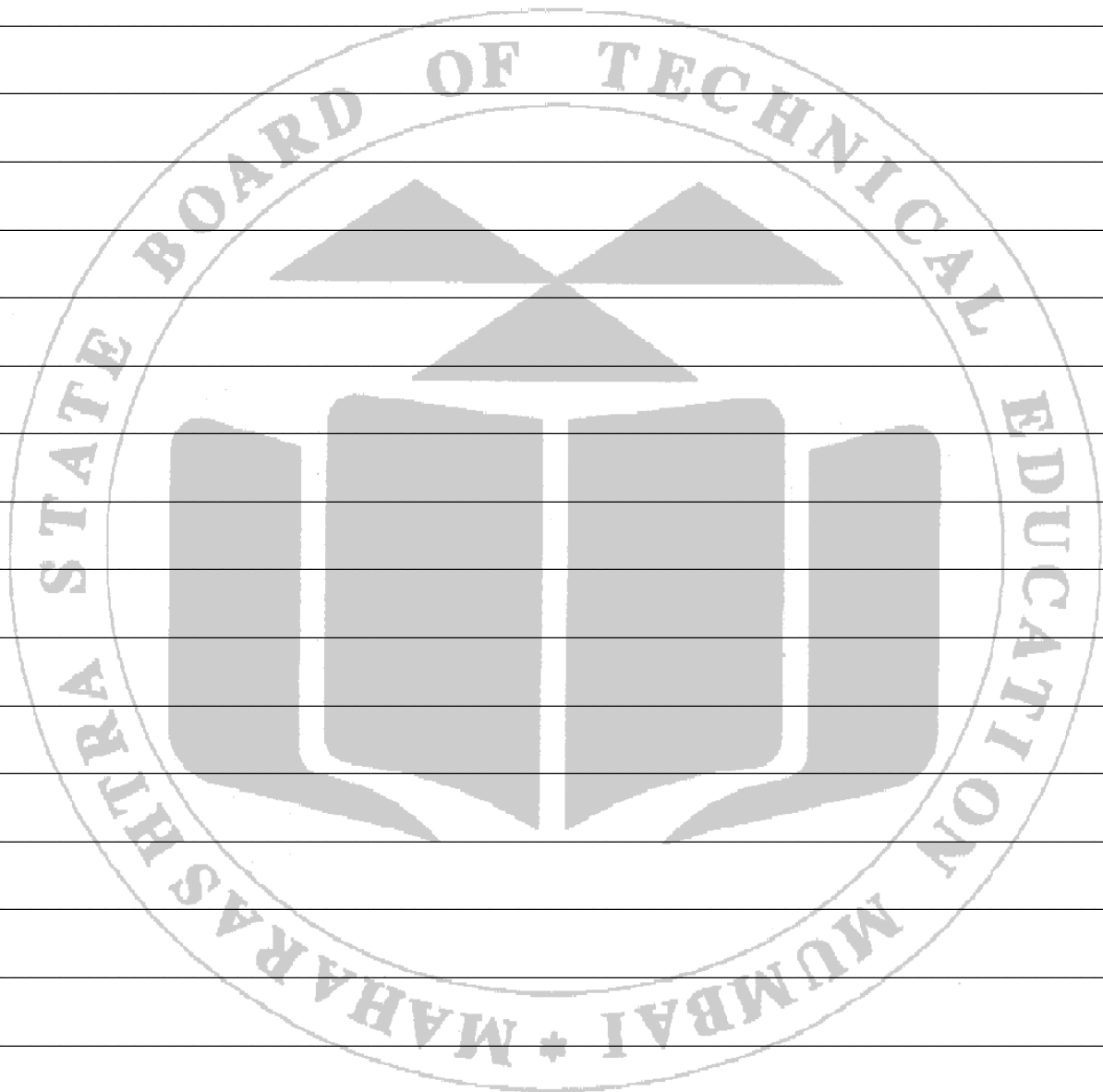
Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications



**Report on Various Antibiotics Dispensed**



## WEEK 13 REPORT

Day	Date	Number of prescriptions dispensed	Number of patients counseled	Remarks
1				
2				
3				
4				
5				
6				
7				

**Important instructions:**

- Provide 10 prescriptions you have dispensed during this week, including all the details as per the provided format.

Signature of the Student

Signature of Apprentice Master

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

## Copy of Prescription

Date: \_\_\_\_\_

R

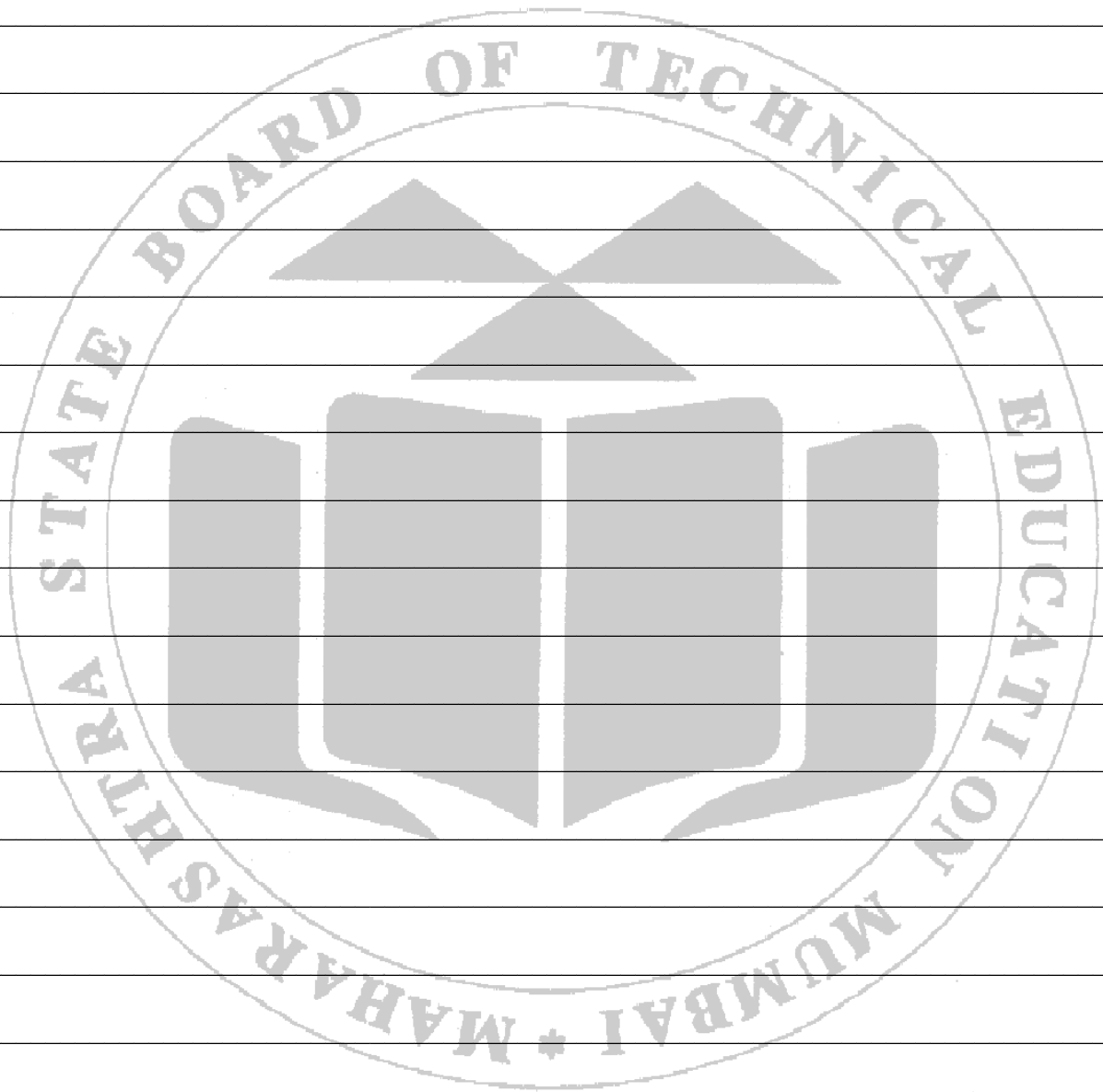
Name of the Doctor: \_\_\_\_\_ Qualification: \_\_\_\_\_

Name of the Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M/F

Diagnosis: \_\_\_\_\_

Branded/generic drug name	Dose	Route of administration	Frequency	Indications

**Report on Experiences in Counseling Diabetic and Hypertensive Patients**

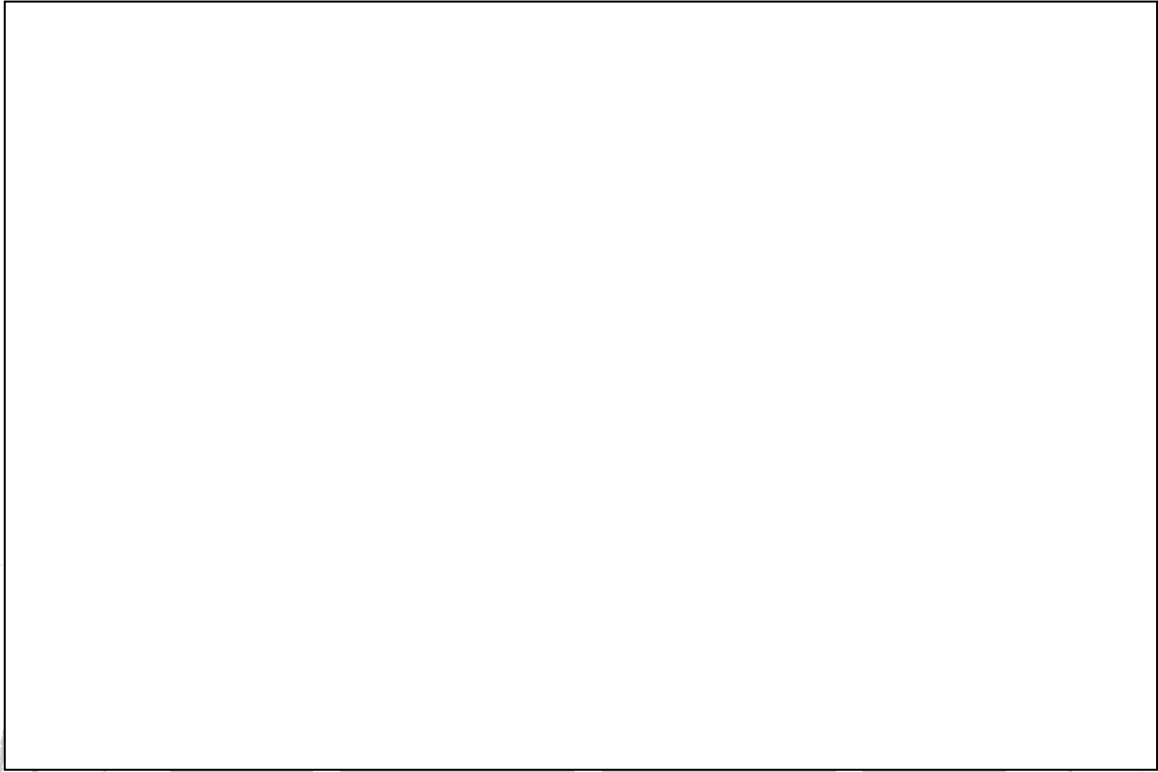




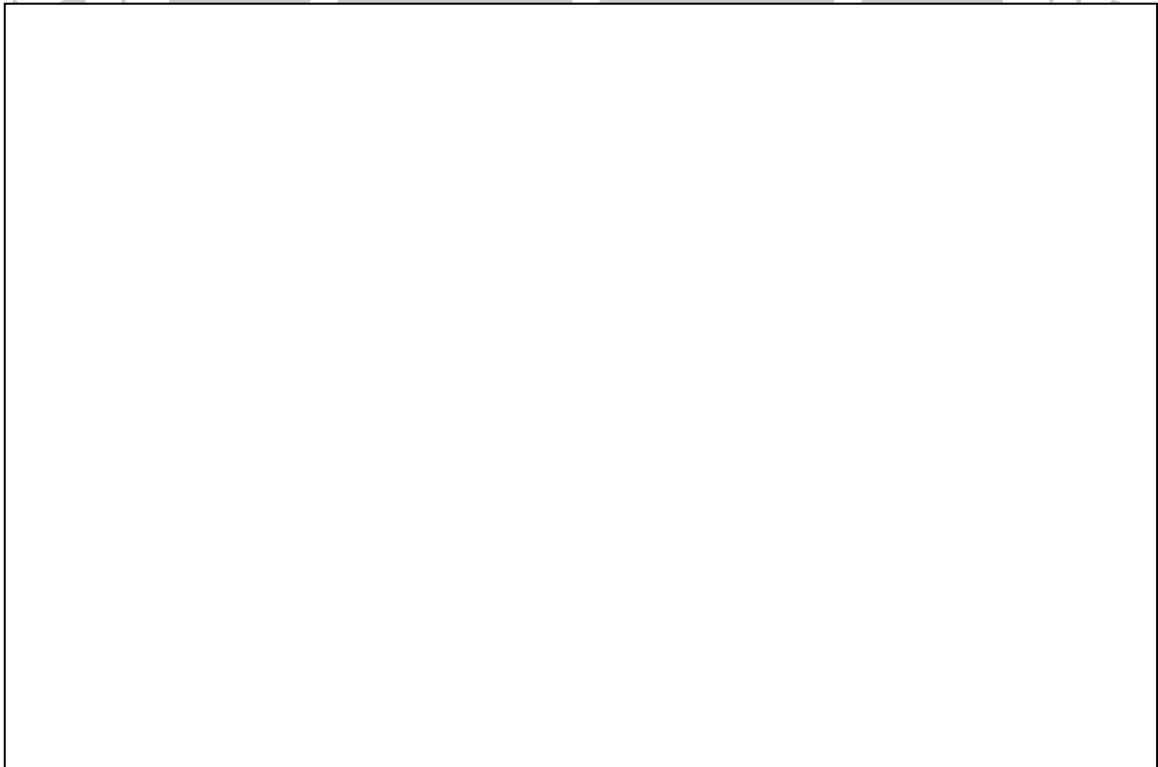
**COUNSELING REPORT**

(Students should paste minimum 6 photographs while counseling the patient)

**Photograph 1:** \_\_\_\_\_



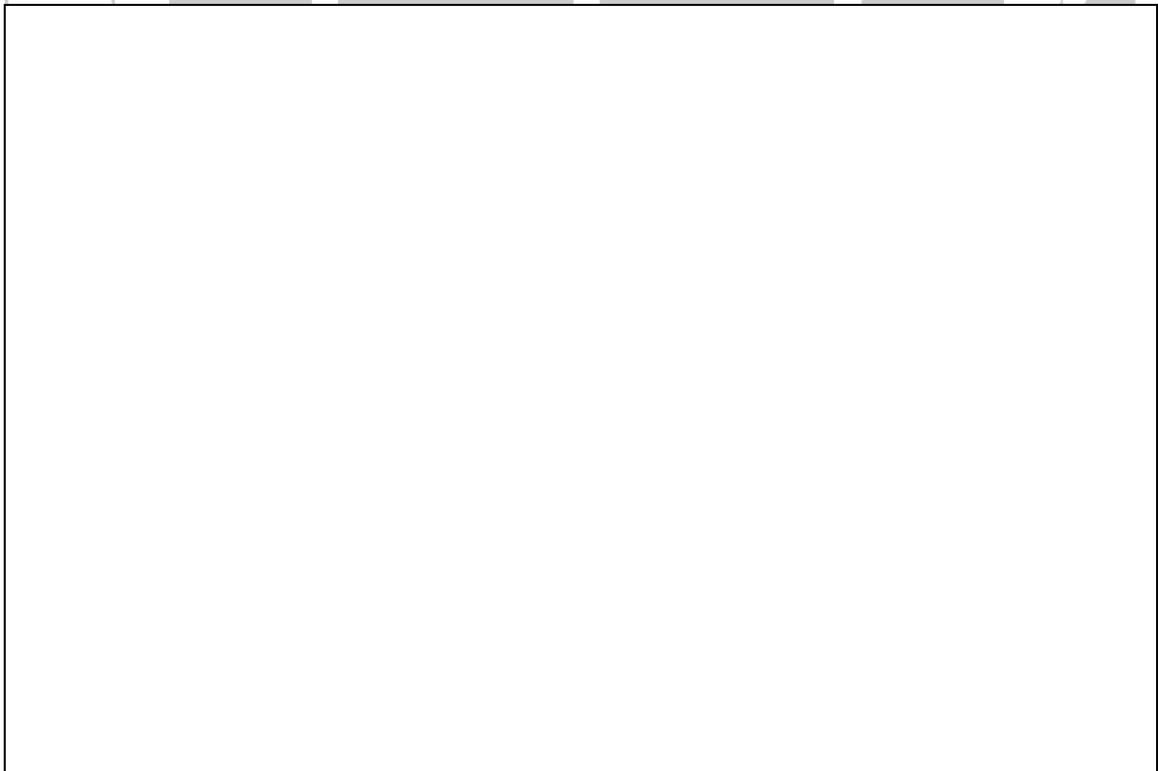
**Photograph 2:** \_\_\_\_\_



**Photograph 3:** \_\_\_\_\_



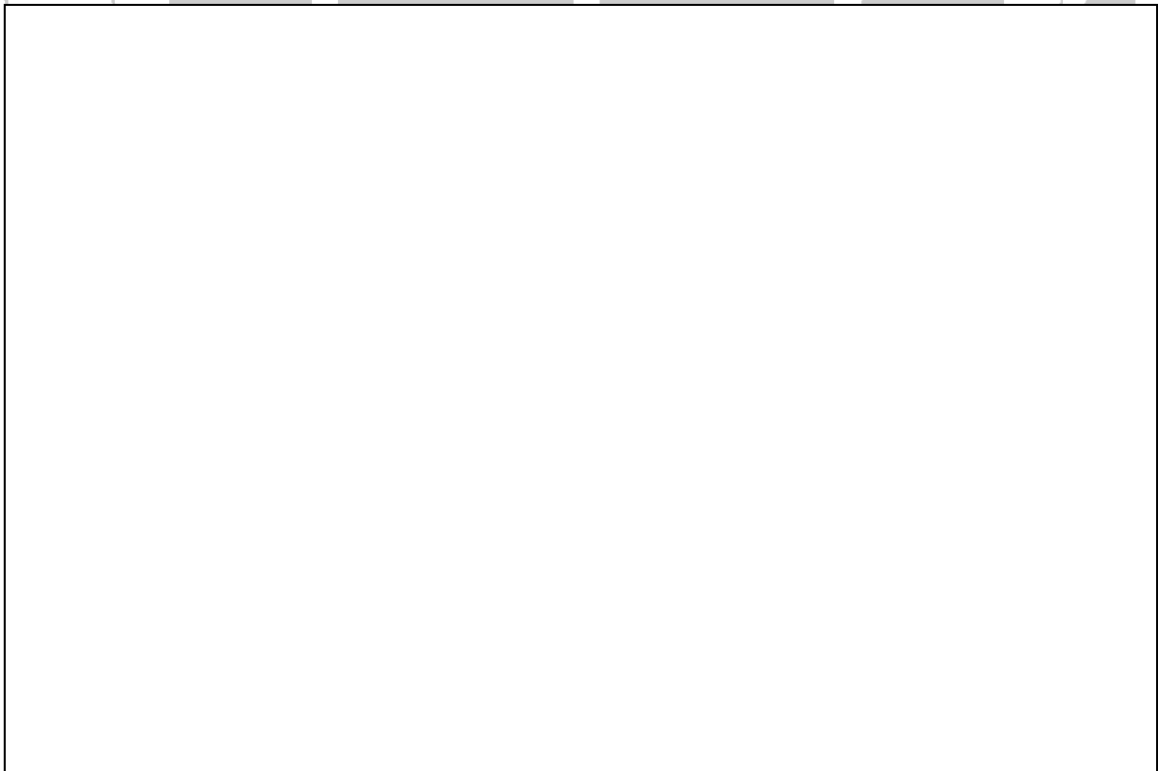
**Photograph 4:** \_\_\_\_\_



**Photograph 5:** \_\_\_\_\_



**Photograph 6:** \_\_\_\_\_



1. Name the products of the following dosage form with the brand name and company name.

Dosage form	Brand name	Company name
Tablet		
Capsule		
Syrup		
Suspension		
Gel/cream for external application		
Injection		
NaCl Intravenous infusion		
DNS Intravenous infusion		

**2. Name five dosage form/ formulations based on NDDS (New Drug Delivery System) along with their ingredients.**

Sr. No.	Formulation type	Formulation Name	Mfg by / company name	Ingredients
1.				
2.				
3.				
4.				
5.				

**3. Provide details of generic and branded drugs available at the medical store.****A. Generic drugs:**

Sr. No.	Generic name	Dosage form	Dose	Manufacturer	Indication	Price (Rs)
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

**B. Branded drugs:**

Sr. No.	Brand name	Drug / Drugs	Dosage form	Dose	Manufacturer	Indication	Price (Rs)
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

[illegible]

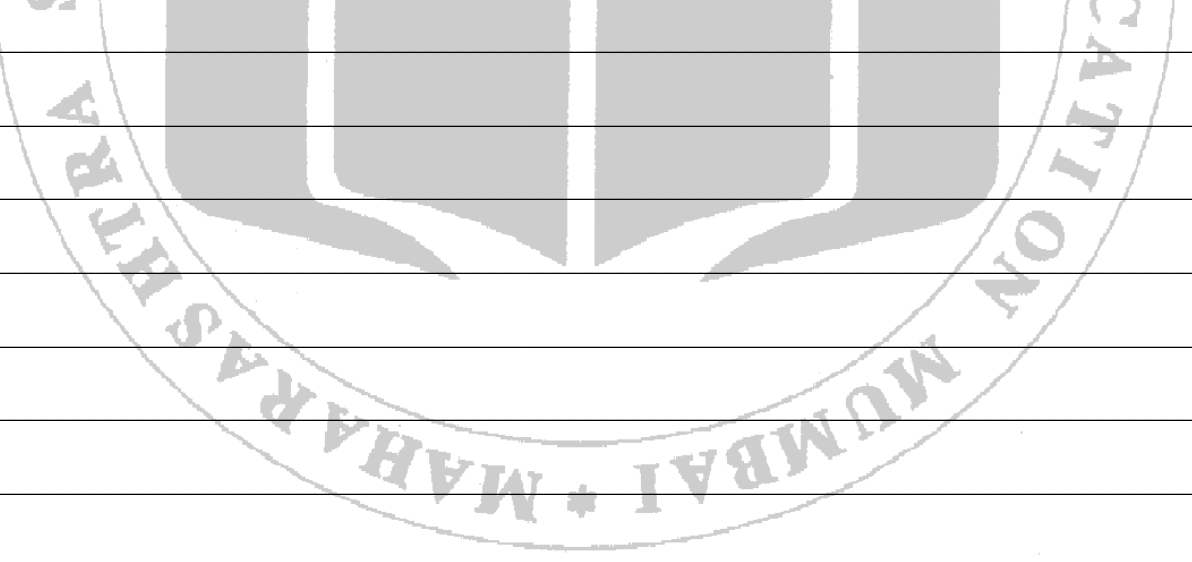
5. List the five formulations stored at 2–8°C along with their indications.

Sr. No.	Product name	Indications

6. List any five formulations that are generally contraindicated in patients with the following condition:

Patient condition	Contraindicated formulations
Breastfeeding	1.
	2.
	3.
	4.
	5.
Children below the age of 12 years	1.
	2.
	3.
	4.
	5.
Renal and metabolism compromised older patients	1.
	2.
	3.
	4.
	5.

**8. Describe the dietary and lifestyle recommendations for diabetic and hypertensive patients.**





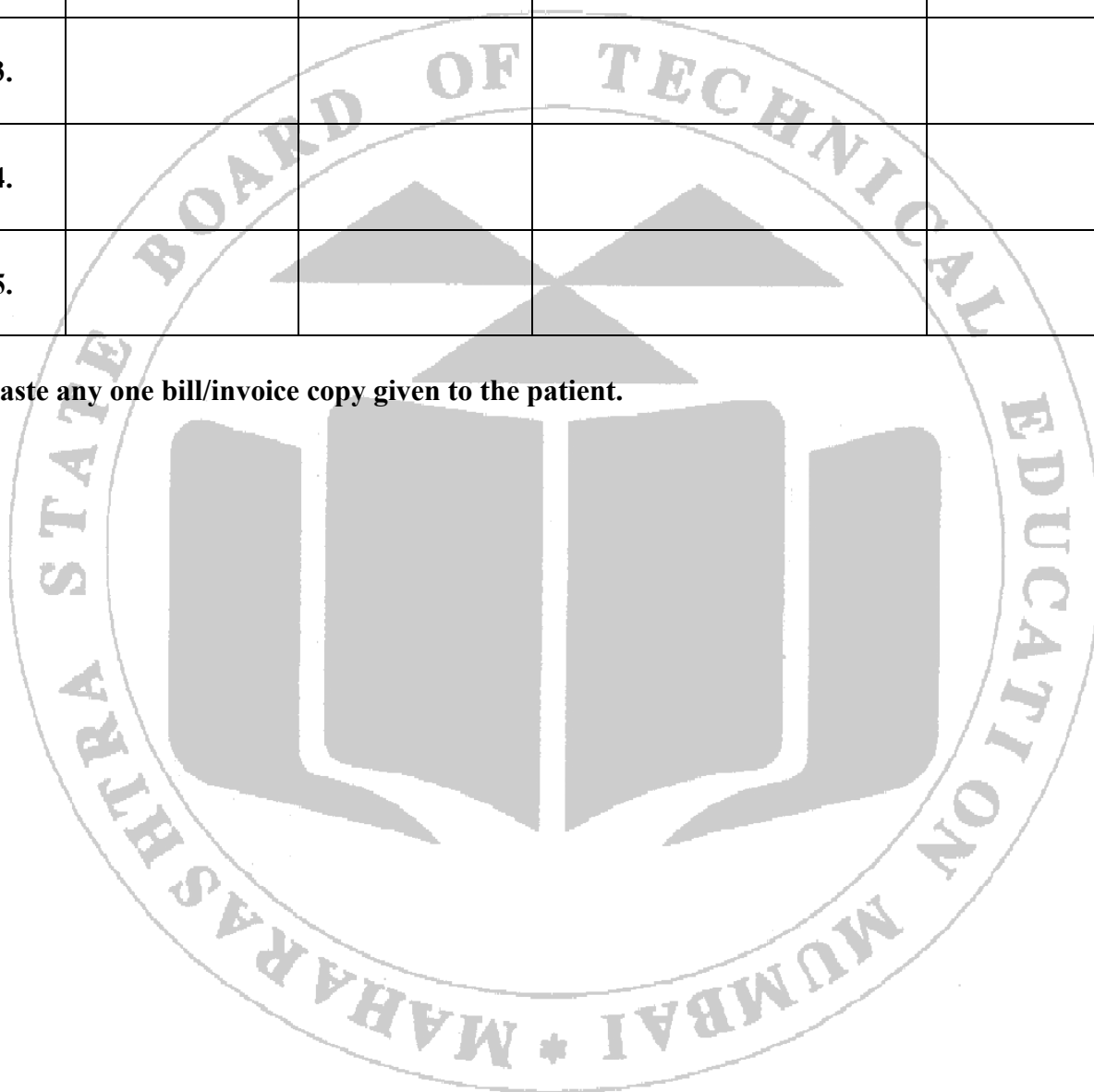
9. List the instructions you should give to patients when dispensing the following formulations.

Sr. No.	Formulation	Instructions
1.	Ointment	
2.	Ear drop	
3.	Eye drop	
4.	External Cream	
5.	Emulsion	
6.	Hair dye	
7.	Inhaler	
8.	Antibiotic dry syrup for child	

**10. List the top five best-selling brands in your training pharmacy/medical store.**

Sr. No.	Brand	Contents	Sale during your training (Rs.)	Yearly sale (Rs.)
1.				
2.				
3.				
4.				
5.				

**11. Paste any one bill/invoice copy given to the patient.**



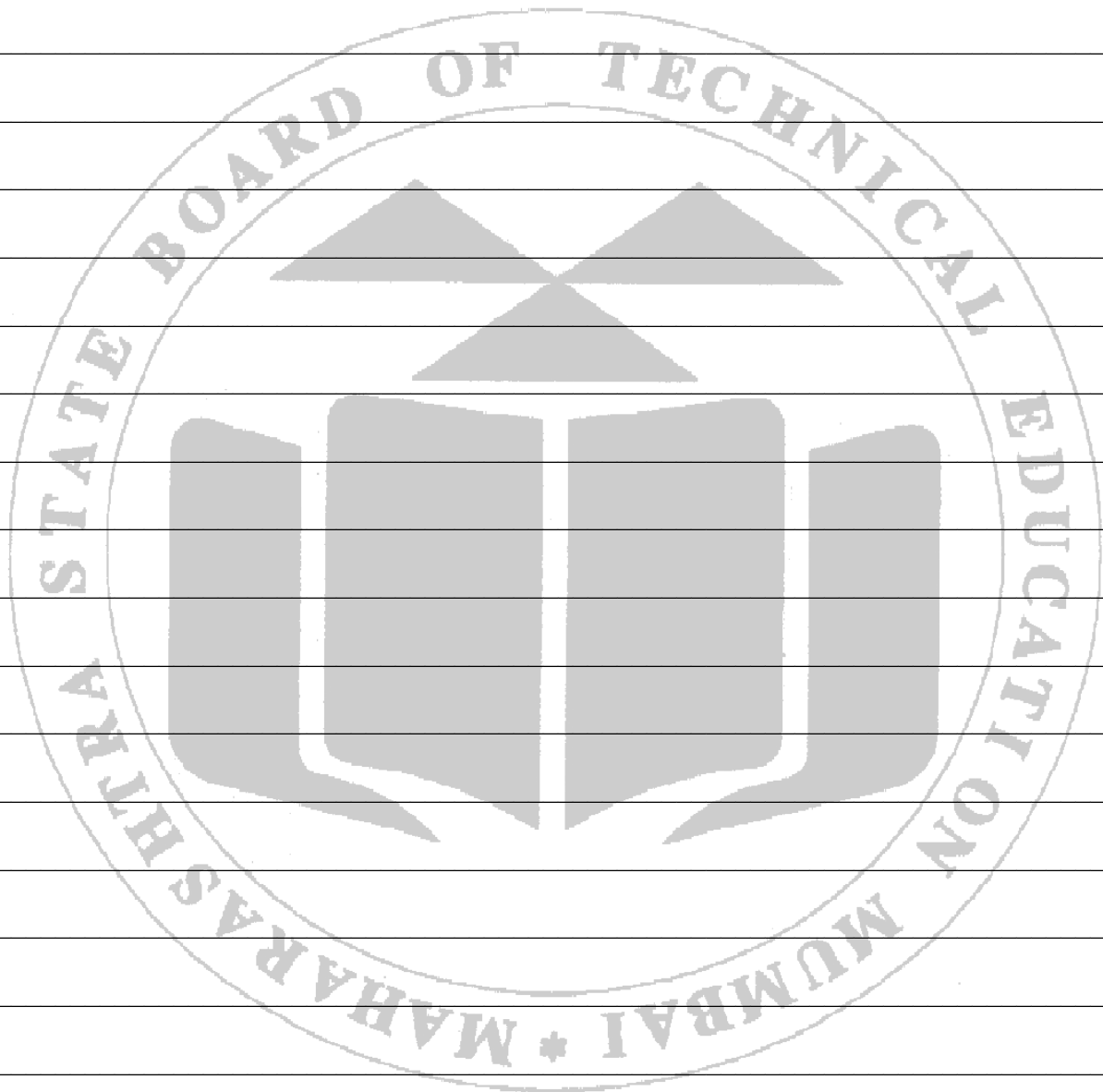
### 13. How are the formulations organized within the medical store?

**Maharashtra State Board of Technical Education ('J' Scheme)**



## TRAINING OUTCOME

Describe your three-month practical training experience.



## RATING OF STUDENT'S PERFORMANCE BY APPRENTICE MASTER

Name of the Student: \_\_\_\_\_

Sr No	Characteristics	Rating			
		Very good	Good	Satisfactory	Unsatisfactory
1.	Regularity				
2.	Punctuality				
3.	Accuracy				
4.	Neatness				
5.	Initiative				
6.	Insight for the understanding of the work				
7.	The sense of carrying out the assigned work				
8.	Involvement in the work				
9.	Willingness to take up the additional work				
10.	Maturity in interpersonal reactions				

Other Observations, if any: \_\_\_\_\_

Place: \_\_\_\_\_

Date: \_\_\_\_\_

Seal

Name & Signature of Apprentice Master

## PRACTICAL TRAINING PROJECT ASSESSMENT

Name of the Student: \_\_\_\_\_

Enrolment No. \_\_\_\_\_ Roll No. \_\_\_\_\_

Exam Seat Numbers for **First year** \_\_\_\_\_ **Second Year** \_\_\_\_\_

Practical Training Period Starts From Date \_\_\_\_\_ to Date \_\_\_\_\_

Project Submitted Date: \_\_\_\_\_

Signature of student

Name of the Project Guide: \_\_\_\_\_

Date of Test / Viva conducted: \_\_\_\_\_

Test / Viva remarks: **Excellent/Very Good/Good/Satisfactory/Non-Satisfactory**

Grade:

A+	A	B+	B	C
----	---	----	---	---

Name & Signature of the Project Guide

Signature of Principal

Seal of the Institution