CEYLON MEDICAL COLLEGE COUNCIL
TRAINEE PHARMACIST ATTENDANCE RECORD

Duration: Four (4) Months Internship

Trainee Pharmacist Details

Name of Trainee Pharmacist: _____

Index Number: _____

Registration Number (if applicable): _____

Internship Period: From _____ To _____

Pharmacy Details

Name of Pharmacy: _____

Address of Pharmacy: _____

_____

Contact Number: _____

NMRA Registration Number : _____

B. Supervising (Master) Pharmacist Details

Name of Supervising Pharmacist: _____

SLMC Registration Number: _____

Contact Number: _____

D. Attendance Record (4 Months)

Minimum required attendance: 80% | 8-hour shifts | 6 days per week | Saturdays are allocated for academic activities. **Working hours are from 8.30 to 5.30 or 8.00 am to 5.00 pm**

Date	Day	Time In	Time Out	Total Hours	Supervisor Signature

Monthly Attendance Summary

Month	Total Working Days	Days Present	Days Absent	Attendance %	Supervisor Signature
Month 1					
Month 2					
Month 3					
Month 4					

Final Verification

I hereby certify that the above attendance record is true and accurate to the best of my knowledge.

Supervising Pharmacist / Owner pharmacist/ Head of Human Resource - CFC/ Cargills/ relevant organization

Signature: _____

Name: _____

SLMC Registration No: _____

Date: _____

Official Seal/Stamp:

Note: Please attach a certified copy of the manual attendance register or fingerprint record as evidence of attendance certified by the Owner Pharmacist or head of the Chain Pharmacy outlet