

Pharmacy 591
20 HOUR COMMUNITY
SERVICE PROJECT



The University of Findlay
School of Pharmacy
Community Service Record Form

Name: _____ Date: _____

E-mail:

Phone, including area code:

Description:

(Please describe the project below or on attached page, include expected time to complete project.)

Approved by: _____ Date: _____
Faculty Signature

Project Details:

Name of Supervisor:

Supervisor Title and Organization: (attach business card, if possible)

Supervisor Phone Number (including area code):

Supervisor e-mail:

Number of Hours Completed:

Brief Description of Activities Completed (attach sheet – on organization stationery, if possible):

By signing below, the Supervisor is indicating that the work of this student on the approved project is totally completed and acceptable.

Signature of Supervisor: _____ Date _____