**Student Final Evaluation report after state exam practice**

**Name of Pharmacy / Hospital Pharmacy, Address of Pharmacy/Hospital Pharmacy:**

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**Name of Pharmacist, responsible for Education:**

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**Name of Student:-----------------------------------------------------------------------------------------**

**Duration of State exam practice:-----------------------------------------------------------------------**

**Qualification level (please underline):**

**excellent**

**satisfactory**

**failed**

**Brief evaluation report:**

**Date:-----------------------------------------------------------------------------**

**Signature:-----------------------------------------------------------------------**

**Stamp --------------------------------------------------------------------------**