PRE-PHARMACY CLUB UC DAVIS 

HEALTH PROFESSIONS ADVISING (HPA) MEETING FORM

**FULL NAME:**

**EVENT NAME:**

**DATE:**

**LOCATION:**

**TIME OF MEETING:**

**INFORMATION LEARNED FROM THIS EVENT:**

**COORDINATOR’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRE-PHARMACY OFFICER’S APPROVAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**