Research and Scholarship Certificate Program Application Form

AMERICAN COLLEGE OF CLINICAL PHARMACY ACADEMY

Today's date: _____

Name (last, first, middle initial): _____

Address: _____

City: _____

State: _____ Zip code: _____

Work phone: _____ E-mail: _____

Are you an ACCP member? ☐ Yes ☐ No

Current position/title: _____

Primary practice or professional setting (e.g., academia, acute care, ambulatory care, industry, etc.): _____

_____

Employer: _____

Pharmacy degree(s): _____ Year(s) of graduation: _____

Other degrees (B.S./B.A., Master's, Ph.D., other): _____

Postgraduate Training (✔):

_____ Residency (general/PGY1) Year completed: _____

_____ Residency (specialized/PGY2) Year completed: _____

_____ Fellowship, Program duration (yrs): Year(s) completed: _____

Board Certification(s) (specify credential): _____

Have you attended previous research or scholarship development programs? ____

Have you received previous postgraduate education research? ____
If yes, select the type of previous education or training received:

___ Master's degree

___ Ph.D.

___ Research seminars/presentations at professional meetings

___ Multi-day research seminars/camps

___ Research training at your place of employment

Is serving in a research position among your career goals? ____

Have you submitted a research grant proposal? ____

Have you served as the primary author on any of the following?
___ Research paper
___ Research abstract
___ Review article
___ Case report
___ Other (specify): _____)

If you are currently pursuing research, please indicate your major area of research:
___ Basic sciences research
___ Clinical and translational research
___ Health services research
___ Pedagogical research
___ Other (specify): _____)

I am enrolling in this certificate program because (✔):
____ I desire to enhance my research and scholarly abilities
____ The program is required by my employer
____ The program was suggested by my employer
____ The program was recommended by a colleague
____ Other (please specify reason): _____)

Do you currently have a mentor related to your research/scholarly responsibilities? ____

Whom would you select to be a mentor during your study within this program? Please indicate this individual's title; provide name, if possible: _____

Method of Payment
A one-time non-refundable fee of $150 will be charged for enrollment in the certificate program.

Total enrollment fee: $150.00

☐ Check Enclosed (U.S. funds only), payable to the American College of Clinical Pharmacy

☐ Charge to ☐ AMEX ☐ DISC ☐ MC ☐ VISA

Card Number _____

Exp Date _____ / _____ Security Code _____

Signature _____

Please mail or fax this application to:
ACCP
13000 W. 87th St. Parkway, Suite 100
Lenexa, KS 66215-4530
Fax: (913) 492-0088