

Research and Scholarship Certificate Program Application Form



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[s] and year[s] earned): _____

Have you attended previous research or scholarship development programs? ☐ Yes ☐ No

Have you received previous postgraduate education research? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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 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

Or email Zangi Miti - zmiti@accp.com