

**Career Advancement 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) Specialty: _____

Year completed: _____

_____ Fellowship, Program duration (yrs): Specialty: _____

Program duration (yrs): _____

Year(s) completed: _____

Board Certification(s) (specify credential[s] and year[s] earned): _____

Other Credential(s) (specify credential[s] and year[s] earned): _____

Have you attended other formal clinical practice development programs? ___yes ___ no

If yes, please specify program and year completed: _____

Have you attended other formal preceptor development programs? ___ yes ___ no

If yes, please specify program and year completed: _____

On average, how many pharmacy students do you precept each year? _____

On average, how many pharmacy residents do you precept each year? _____

Do you mentor other health care professionals and/or precept other health care professional trainees?

If yes, briefly describe. _____

Have you received any preceptor or clinical practice awards? If yes, please specify award and year: _____

Describe your scholarly accomplishments at this stage in your career. _____

I am enrolling in this certificate program because (

- I desire to enhance my career as clinical practitioner
- I desire to enhance my precepting and/or mentoring 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: _____)

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