

# 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 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**