Research and Scholarship Academy
Enrollment 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/PGYl) 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): _____

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 _____

Mail, fax, or e-mail application and enrollment fee to:
American College of Clinical Pharmacy
13000 West 87th Street Parkway, Suite 100
Lenexa, Kansas 66215-4530
Fax: (913) 492-0088
E-mail: jculley@accp.com