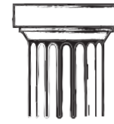
Teaching and Learning Certificate Program Enrollment Form



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.): ____________________

____

If you are in academia, please indicate your practice area(s):____________________

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: ____________________

How many years of teaching experience do you have in experiential education? ☐<1 year ☐1-5 years ☐>5 years

How many years of teaching experience do you have in didactic education? ☐<1 year ☐1-5 years ☐>5 years

Have you attended previous formal preceptor or faculty development programs? ☐ Yes ☐ No

Have you ever maintained a teaching portfolio as a faculty member or preceptor? ☐ Yes ☐ No

Do you currently have a mentor related to your teaching responsibilities? ☐ Yes ☐ No

Do you provide instruction to practitioners and students in other health care professions? ☐ Yes ☐ No

Do you have administrative responsibilities (e.g., Program Coordinator, Chair, Director, Dean)? ☐ Yes ☐ No

I am enrolling in this certificate program because (☑):

☐ I desire to enhance my teaching 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 W. 87th Street Parkway, Suite 100
Lenexa, Kansas 66215-4530
Fax: (913) 492-0088
E-mail: jculley@accp.com