Comprehensive Medication Management
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., hospital/health system, ambulatory clinic, community pharmacy, etc.): _____

_____

Are you a full-time faculty member with a College or School of Pharmacy? ☐ Yes ☐ No

Please indicate your practice specialty(ies):_____

Pharmacy degree(s):_____Year(s) of graduation: _____

Other degrees (B.S./B.A., Master's, Ph.D., other): _____

Postgraduate Training (select any/all that apply) :

☐ Residency (general/PGYl) Year completed: _____

☐ Residency (specialized/PGY2) Year completed: _____

☐ Fellowship Year completed: _____

How many years of practice experience do you have? ☐<1 year ☐1-5 years ☐>5 years

Are you planning to implement new CMM services within the next year? ☐ Yes ☐ No

Have you completed other, practice-based certificate programs? ☐ Yes ☐ No

Have you previously developed a business plan for clinical pharmacy services? ☐ Yes ☐ No

Have you previously developed a collaborative practice agreement? ☐ Yes ☐ No

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

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

☐ I desire to learn more about comprehensive medication management

☐ I desire to learn how to implement comprehensive medication management in my practice

☐ 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 $399.95 for members or $699.95 for nonmembers will be charged for enrollment in the certificate program.

Total Member enrollment fee: $399.95
Total Nonmember enrollment fee: $699.95

☐ 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