

**Teaching and Learning 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[s] and year[s] earned): _____

How many semesters of teaching experience do you have in experiential education? _____

How many semesters of teaching experience do you have in didactic education?

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

Is serving as a full-time faculty member among your career goals? Yes No

Is serving as a part-time or adjunct faculty member among your career goals? 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

Have you received any teaching awards? Yes No

Do you have a full-time academic appointment? Yes No Do you precept students? Yes No

Do you teach in didactic courses? Yes No As a lecturer? Yes No As a discussion leader? 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: _____)

Please indicate if you have previously attended the ACCP session listed below ():

Using Cases to Enhance Learning Outcomes (Monterey, April 2006)

All other sessions previously attended are on record at ACCP.

Method of Payment

A one-time fee of \$399.95 for members and \$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: mmerrigan@accp.com