APPLICATION FOR ACCREDITATION OR REACCREDITATION OF AN INTERNATIONAL PHARMACY PRACTICE RESIDENCY PROGRAM

Please check one: ☐ Initial Application ☐ Reaccreditation

Please check one: ☐ Pharmacy Practice ☐ Advanced Pharmacy Practice

This form must be completed and submitted to ASHP's Practice Advancement Office at the time of application for accreditation or reaccreditation.

Name of Organization: _____

Address:_____

City/State/Zip:_____

Telephone: _____

Country: _____

TERMS AND INFORMATIONAL REQUIREMENTS

1. The above organization is applying for ASHP accreditation/reaccreditation of an international pharmacy practice residency program. This application form must be completed in full; signed by the residency program director, the director of pharmacy, and the CEO; and accepted by the ASHP Practice Advancement Office before any further actions will occur on the application.

2. The organization named above accepts and understands the sole basis for accreditation/reaccreditation are the requirements in the currently effective *Administrative Procedures on Accreditation of International Pharmacy Practice Residencies,* and the currently effective *ASHP Accreditation Standard for International Pharmacy Practice Residency Programs (Standards*) or the *ASHP Accreditation Standard for International Advanced Pharmacy Practice Residency Programs (Standards)*. The current documents are available on the ASHP website, www.ashp.org. These administrative procedures and Standards are incorporated by reference into this application form.

3. To the best of our knowledge, the residency program of this organization for which accreditation/reaccreditation is being sought meets the requirements of the accreditation Regulations and Standards by which the residency program will be reviewed.

4. The organization agrees and accepts that any and all decisions to award accreditation/reaccreditation to the residency program of the organization is contingent upon the residency program being in compliance with the relevant accreditation Regulations and Standards, as determined by the official ASHP survey and review process.

5. All decisions to accredit or reaccredit a pharmacy residency program are determined solely through the ASHP International Accreditation Commission as authorized by the ASHP Board of Directors.

6. The pharmacy residency program for which accreditation is being sought has been in existence for _____ years.

7. This organization conducts other ASHP-accredited, preliminarily-accredited, candidate, or pre-candidate status residency programs. ☐ Yes ☐ No

   If yes, please list other programs: _____

8. If application is for initial accreditation, the following are highly recommended prior to application or prior to the start of the first class of residents (highly recommended for all residency program directors):
   a. The residency program director for this residency attended ASHP workshop(s) or educational sessions about residency program and/or preceptor development on (month/year): _____
   b. The residency program director and/or preceptors for this residency program have attended an ASHP Residency Program Design and Conduct Workshop(s) in (month/year) _____
   c. The residency program director conducted an evaluation of this program using the applicable "Pre-survey Questionnaire and Self-Assessment Checklist" to see that the residency program meets the accreditation Standard and ASHP Best Practices in (month/year) _____. (Submission of this document is not required until 45 days prior to site visit)

9. This residency is conducted at: ☐ one site ☐ multiple sites (Multiple site programs are those whereby residents spend greater than 25% of the program time at a second site). If multiple sites are used for this program, how many sites are used? _____. Please provide the name(s) of sites:_____

   _____

   Indicate the distance in miles/kilometers between the home site and all other practice sites used for the program
   _____

   _____

10. The last resident(s) to complete this residency graduated (mo/yr) _____. Name(s) of those residents:
    _____

11. The current resident began this residency program in (month/year):_____
    How many residents are enrolled in the residency program at the time of this application? _____
    List full names of current residents: _____
    _____

Having read and understood the above application form, the Terms and Required Information, and the Regulations and applicable Standard for accreditation, the Organization agrees to the requirements outlined, and certifies that the responses provided in the application are correct and accurate.

Residency Program Director's Information:

Name: _____
Title: _____
Phone: _____
E-Mail:_____

_____
Signature, Residency Program Director

Director of Pharmacy's Information:
(if College sponsored, individual to whom the Residency Program Director reports):

Name: _____

Title: _____
Phone: _____

E-Mail_____

_____
Signature, Director of Pharmacy

Chief Executive Officer's Information:
(if College-sponsored, Dean of College of Pharmacy):

Name: _____
Title: _____
Phone: _____

_____
Signature, Chief Executive Officer/Dean
(If CEO address is different from the Organization's address, please supply.)

DATE SUBMITTED: _____

ASHP Use Only:
Program Code:
ID Number:
Date Received: