# APPLICATION FOR ACCREDITATION OR REACCREDITATION

# OF A PHARMACY RESIDENCY PROGRAM

Please check one:  Initial Application  Reaccreditation

**This form must be completed and submitted to ASHP's Accreditation Services Office at the time of application for accreditation or reaccreditation of a residency program.**

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| Please check one: PGY1 | PGY2 If PGY2, specialized area:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| (If PGY1 Community Pharmacy or PGY1 Managed Care Pharmacy Residency – please see separate application form.) | |
| Name of Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| City/State/Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Terms and Informational Requirements**

1. The above organization is applying for ASHP accreditation/reaccreditation of a pharmacy 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 Accreditation Services Office before any further actions will occur on the application.

2. The organization named above accepts and understands the sole basis for accreditation/reaccreditation is the requirements in the currently effective *ASHP Regulations on Accreditation of Pharmacy Residencies* (Regulations), and the currently effective *ASHP Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Residency Programs* or *ASHP Accreditation Standard for Postgraduate Year Two (PGY2) Pharmacy Residency Programs* (Standards). (See: <https://www.ashp.org/Professional-Development/Residency-Information/Residency-Program-Directors>) All of these Regulations 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 Commission on Credentialing 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 an ASHP "Applying for Accreditation – Finding the Pathway and Taking the Right Steps" discussion session in (month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. The residency program director for this residency attended an ASHP Residency Program Design and Conduct (RPDC) workshop 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 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 (sites where residents spend greater than 25% of the program time). If multiple sites, how many? \_\_\_\_\_\_\_\_\_\_. Name of sites:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Distance in miles between sites?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. The last resident to complete this residency graduated (mo/yr) \_\_\_\_\_\_\_\_. Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If PGY2 residency, last resident graduated from pharmacy school (mo/yr):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. The current resident began this residency program in (month/year):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many residents currently? \_\_\_\_\_\_\_\_

List full names of current residents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. If this is a PGY1 pharmacy residency, are you eligible for Medicare pass-through funding?

Yes  No  Unknown

If yes, do you (or will you be attempting to) obtain CMS funding?  Yes  No

Do you obtain funding from other sources?  Yes  No If yes, please explain.

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.

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| **Residency Program Director’s Information:** | **Chief Executive Officer’s Information:**  (if College sponsored, Dean of College of Pharmacy): |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature, Residency Program Director | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Signature, Chief Executive Officer  **(If CEO address is different from the Organization’s please supply.)** |
|  | **DATE SUBMITTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Director of Pharmacy’s Information:**  (if College sponsored, individual to whom the Residency Program Director reports): | **ASHP Use Only:** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Program Code:** |
| Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **ID Number:** |
| Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **NMS Code:** |
| Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Date Received:** |
| E-Mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Signature, Director of Pharmacy |  |