

**Request to Add a Community-Based Primary Practice Site to an Existing Accredited Residency Program**

**Type All Information**

Program 5 digit ASHP Code:

Program Name:

Program Address:

Residency Program Director (RPD):

RPD Email:

RPD Phone Number:

Current number of Primary Practice Sites (PPS):

List names and locations (city and state) of all current PPS:

If operated by a School or College of Pharmacy, provide full name and address:

**PGY1 Community-based Multiple Practice-Site** pharmacy residencies with more than one Primary Practice Site\* must also comply with ALL of the following additional requirements:

* + 1. The residency program is limited to no more than five PPS.
    2. A minimum of 40% of training is completed at the resident’s PPS.
    3. The maximum distance between all PPS is no more than 120 miles.
    4. Pay and benefits are comparable for all residents.
    5. Residency policies are the same for all residents.
    6. The RPD must conduct (at a minimum) quarterly in-person visits to each PPS.
    7. **The RPD must notify the Accreditation Services Office (asd@ashp.org) of any deletions or additions to the program’s PPS.**

**Review the following requests for information and enter a response:**

Name of Store/Location to be added as a PPS:

Full Address of Store/Location:

Site Coordinator (SC) Name and Email:

Hours worked at this site by the SC:

Learning experience(s) precepted by the SC:

Mileage distance to next closest PPS, include store/location name and address:

What percentage of time will the new PPS be used for training residents?

Will other Practice Sites\*\* in addition to this Primary Practice Site be used?

If yes, list all additional practice sites, including training purpose and percentage of time used for training:

Has this site been used before and deleted from the structure? Y/N

Effective date this PPS will be used for residency training:

**ATTACHMENTS FOR REVIEW BY ASHP ACCREDITATION SERVICES**

1. List of required and elective learning experiences for the accredited program.
2. Site Coordinator Academic and Professional Record.
3. Number of pharmacists acting as preceptors at this new PPS:
   1. Provide Academic and Professional Records for each additional preceptor if not the SC.
4. Store/Location Manager or PIC Name, Email and Phone Number:

**Printed Name of RPD**

**Signature of RPD (digital ok)**

**If Operated by a School of Pharmacy:**

**Printed Name of the Dean**

**Signature of the Dean (digital ok)**

**Date Submitted**

SUBMIT COMPLETED FORM AND ATTACHMENTS VIA EMAIL TO [ASD@ASHP.ORG](mailto:ASD@ASHP.ORG)

**FOR ASHP REVIEW**

ASHP ASO Reviewer(s)

Year of last accreditation survey:

COC decision on length of accreditation:

Decision: Approve or Deny

Denial Reason:

Date RPD informed:

Date NMS Informed:

Date PharmAcademic Informed:

ASD Records (Fabric Note and TRIM):

**Definitions from the *Regulations on the Accreditation of Pharmacy Residencies (2023)*:**

**\*Primary Practice Site:** the physical location designated by the Program Operator where the majority of a resident’s training in conducted.

**\*\*Practice Site**: A physical location (e.g., hospital campus, FQHC, community pharmacy, specialty pharmacy, managed care facility, outpatient clinic) where the resident completes a learning experience.