# 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. Please type all information requested.**

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| Please check: [ ]  PGY1 | [ ]  PGY2 Advanced Area\*: |
| If a combined (PGY1/PGY2) program check both PGY1 and PGY2 boxes and indicate type in PGY2 area listed above.If PGY1 Community-based Pharmacy or PGY1 Managed Care Pharmacy Residency-please see separate application form.\*An organization seeking to apply for ASHP accreditation of a PGY2 pharmacy residency in an advanced area of pharmacy practice for which ASHP has not developed a set of educational competencies, goals, and objectives must contact ASHP Accreditation Services before applying. |
| Name of Organization/Program Operator\*: |
| Address: |
| City/State/Zip:\*Program Operator is the organization that has ultimate authority for the conduct of the residency program. If conducted in a hospital seeking CMS pass through funding for PGY1, the name of the organization/program operator must match the CMS cost report name of the hospital. This name will appear formally in accreditation records and must appear on residency certificates of completion. For residencies in which the program operator is a college or school of pharmacy, the partnering organization can be listed above after the name of the program operator.  |

**Terms and Informational Requirements**

1. The above organization/program operator 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, the CEO (or Dean if a college of pharmacy) and dated. **If not already supplied with a previous precandidate status application, the CV and Academic and Professional Record of the residency program director (RPD) must be supplied along with this application form.** Application and RPD credentials must be reviewed and accepted by the ASHP Accreditation Services Office before any further actions will occur on the application.

2. The organization/program operator 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). All of these Regulations and Standards are incorporated by reference into this application form. 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 for accreditation.

3. The organization/program operator agrees and accepts that any and all decisions to award accreditation/reaccreditation to the residency program 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.

4. 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.

5. This organization/program operator conducts other ASHP-accredited, candidate, or pre-candidate status residency programs at this location: [ ]  Yes [ ]  No If yes, please list other programs along with their respective ASHP ID codes listed on the directory:

6. A Precandidate Status Application for this program was submitted prior to this new application: [ ]  Yes [ ]  No Date:

7. This residency program is conducted at [ ]  one site, or [ ]  multiple sites (locations where residents spend greater than 25% of the program time).

If multiple sites are used, list names, locations (city/state) and percentage of residency time spent at each site:

8. The pharmacy residency program for which accreditation is being sought has been in existence for \_\_\_\_\_ years.

9. The last resident(s) to complete this residency program graduated (Month/Day/Year):

 Name(s):

10. The current resident(s) began this residency program on (Month/Day/Year):

 Name(s):

11. The following are highly recommended for the residency program director prior to the start of the first class of residents:

A. Attending an ASHP Residency Program Design and Conduct (RPDC) workshop

B. Conducting a self-evaluation of this program using the applicable "Pre-survey Questionnaire and Self-Assessment Checklist" to ascertain that the program meets the accreditation Standard and ASHP Best Practices

(Submission of this document is not required until 45 days prior to an on-site accreditation survey visit.)

12. **Application fees and annual accreditation fees are nonrefundable.**

Having read and understood the above application form, the Terms and Required Information, and the Regulations and applicable Standard for accreditation, the Organization/Program Operator agrees to the requirements outlined, and attests that the responses provided in the application are correct and accurate by signatures affixed below.

**Type Information**. **Electronic Signatures are allowed.**

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