

Teaching and Learning Certificate Program Application Form



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): _____

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? _____

Is serving as a full-time faculty member among your career goals? _____

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

Have you ever maintained a teaching portfolio as a faculty member or preceptor? _____

Do you currently have a mentor related to your teaching responsibilities? _____

Have you received any teaching awards? _____

Do you have a full-time academic appointment? _____ Do you precept students? _____
Do you teach in didactic courses? _____ As a lecturer? _____ As a discussion leader? _____
Do you provide instruction to practitioners and students in other health care professions? _____
Do you have administrative responsibilities (e.g., Program Coordinator, Chair, Director, Dean)? _____

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 non-refundable fee of \$150 will be charged for enrollment in the certificate program.

Total enrollment fee: \$150.00

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 _____

Please mail or fax this application to:

ACCP

13000 W. 87th St. Parkway, Suite 100

Lenexa, KS 66215-4530

Fax: (913) 492-0088