# FASHP Recognition Program

**RECOMMENDATION FORM**

**TO THE CANDIDATE**: Please type your name in the space provided and give this form to a colleague\* (i.e., practitioner, administrator or academician) familiar with your contributions to pharmacy practice in acute and ambulatory care settings who can attest to your achievement of the Fellow criteria. This recommendation can be submitted as part of your FASHP application or e-mailed directly to the Office of Member Relations by the person completing it. ***\*Please note, current pharmacy students, current ASHP staff, current ASHP Board members, and current members of the FASHP Recognition Committee are not eligible to submit recommendations.***

|  |  |
| --- | --- |
| **Candidate Name** | Click here to enter text. |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Recommender Name** | Click here to enter text. | | | | | | | |
| **Title** | Click here to enter text. | | | **Affiliation** | Click here to enter text. | | | |
| **Street Address** | Click here to enter text. | | | | | | | |
| **City** | Click here to enter text. | | | | **State** | Click here to enter text. | **Zip** | Click here to enter text. |
| **Daytime Telephone** | Click here to enter text. | **E-mail** | Click here to enter text. | | | | | |
| **Candidate’s professional relationship to you** | | Click here to enter text. | | | | | | |
| **Length of time of relationship with candidate** | | Click here to enter text. | | | | | | |

**TO THE RECOMMENDER**: The individual named above is applying for recognition as a Fellow of ASHP. The FASHP Recognition Program is intended to recognize excellence in pharmacy practice in acute and ambulatory care settings and contributions to ASHP and grant recognition to and promote public awareness of pharmacists who have distinguished themselves.

As part of the application review process, **it is critical that each candidate obtain written assessment from colleagues concerning his or her achievement of the criteria for recognition as a Fellow as contained in the FASHP Program Guidelines.** Feel free to either enter as much text as you would like in the space below or attach a separate letter. You can view the FASHP Program Guidelines and criteria at [www.ashp.org/FASHP](http://www.ashp.org/FASHP).

|  |
| --- |
| Click here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature of Recommender** | Click here to enter text. | **Date** | Click here to enter text. |

**\*Recommendation Form must be signed. Electronic signature is accepted.\***

**Please submit this Recommendation Form, including any additional pages, via e-mail no later than October 1 to the Director, Member Engagement in the Office of Member Relations at** [**Awards@ashp.org**](mailto:Awards@ashp.org?subject=FASHP%20Letter%20of%20Recommendation) **or as part of the online application submission form.**