# APPLICATION FOR ACCREDITATION OR REACCREDITATION

# OF A PHARMACY RESIDENCY PROGRAM

Please check one: [ ]  Initial Candidate Status 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.**

*Candidate Status: Status granted to a program that has a resident(s) in training. Programs without a resident in place and seeking pre-candidate status must complete the Pre-Candidate Status application.*

|  |
| --- |
| **Check Program Type:** [ ]  PGY1 Pharmacy [ ]  PGY1 Community-based [ ]  PGY1 Managed Care [ ]  PGY2 *Indicate PGY2 Advanced Practice Area:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If a combined (PGY1/PGY2) program, check the appropriate PGY1 program type box and the PGY2 box. Then indicate the type of PGY1/2 combined program in the PGY2 Advanced Area space listed above. Combined programs with an associated Masters degree component must also indicate this in program type.\*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 Office (ASO) 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 [this is not referring to the residency program director (RPD) name]. If conducted in a hospital seeking CMS pass through funding for PGY1, the name of the organization/program operator **must** match the name of the hospital as indicated on the hospital’s CMS cost report. 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. The organization/program operator name and address will appear as listed above in the online ASHP residency directory and accreditation database.  |

**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 pre-candidate status application, the Academic and Professional Record (APR) of the 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 Pharmacy Residency Programs* (The Standard). The Regulations and The Standard 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 The Standard 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 Pre-candidate Status Application for this program was submitted prior to this new application: [ ]  Yes [ ]  No Date:\_\_\_\_\_\_\_\_\_\_

7. This residency program is conducted at [ ]  one primary practice site, or [ ]  multiple primary practice sites (*Note:*

*All residency programs are limited to a* ***single*** *Primary Practice Site for all residents in the program with the exception of PGY1 Community-Based Pharmacy residency programs sponsored by a College of Pharmacy. See Appendix A in the Regulations for further requirements). PGY1 Community-Based Pharmacy residency programs sponsored by a College of Pharmacy using multiple primary practice sites must complete Appendices A & B in addition to this application, if applying for initial candidate status. Programs applying for reaccreditation do not need to complete the appendices*.

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 accreditation survey visit.)

12. Application fees must be paid to maintain the program’s application status. **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 The Standard, 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.**

|  |  |
| --- | --- |
| **Residency Program Director’s Information:** | **Chief Executive Officer’s Information:**(if College operated, Dean of College of Pharmacy): |
| Name/Degree: | Name/Degree: |
| 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.)** |
| **Director of Pharmacy’s Information:**(if College operated, individual to whom the Residency Program Director reports): | **DATE SUBMITTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Submit all documents via email to asd@ashp.org** |
| Name/Degree: | **ASHP Use Only:** |
| Title:  | Program Code: |
| Phone:  | ID Number: |
| Fax: Email:Signature, Director of Pharmacy | NMS Code:Date Received: |

**ATTACHMENT A**

(NOTE: To be completed ONLY by PGY1 Community-based Pharmacy Residency Programs sponsored by a College of Pharmacy.)

**Primary Practice Sites Affiliated with this Residency Program (please provide information for each site):**

**Primary Practice Site #1:** **Primary Practice Site #2:**

Address: Address:

City, State, Zip: City, State, Zip:

Phone: Phone:

Pharmacist-in-Charge: Pharmacist-in-Charge:

E-Mail: E-Mail:

**Primary Practice Site #3:**  **Primary Practice Site #4:**

Address: Address:

City, State, Zip: City, State, Zip:

Phone: Phone:

Pharmacist-in-Charge: Pharmacist-in-Charge:

E-Mail: E-Mail:

**Primary Practice Site #5:**  **Primary** P**ractice Site #6:**

Address: Address:

City, State, Zip: City, State, Zip:

Phone: Phone:

Pharmacist-in-Charge: Pharmacist-in-Charge:

E-Mail: E-Mail:

**ATTACHMENT B: *Screening Survey***

# For completion by PGY1 Community-based residency programs sponsored by a college of pharmacy with more than one primary practice site ONLY. To optimize the initial candidate-status application review process and to confirm that residency programs ensure that required learning experiences based at different practice sites are comparable in scope, depth, patient population, and complexity for all residents, the following details on the general characteristics of a community-based pharmacy residency program sponsored by a college of pharmacy prior to the submission of the pre-survey documentation is required. Please complete a survey for EACH primary practice site used in the program.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Name of community pharmacy \*Name of qualified pharmacist preceptor Name of current resident(s)

*\*Each site must have a qualified pharmacist preceptor responsible for overseeing the resident and collaborating with the RPD (the RPD may be the qualified preceptor).*

1. What percentage of time does the resident spend in the following settings (at a sum total of 100%)?

 (a) \_\_\_\_\_\_ % In the community pharmacy

(b) \_\_\_\_\_\_ % Other than the community pharmacy (e.g., school, ambulatory clinic, elective experiences). Please specify:

1. Over the course of the residency year, what percentage of the resident’s time, if any, is dedicated to the following activities (at a sum total of 100% with a minimum of 2/3 devoted to direct patient care)?

 (a) \_\_\_\_\_\_ % Patient-centered dispensing (e.g., patient counseling, recruit patients

 for health and wellness programs)

 (b) \_\_\_\_\_\_ % Additional direct patient care (e.g., medication management, disease

 state management, care transitions)

 (c) \_\_\_\_\_\_ % Practice management (e.g., pharmacy management, practice-related projects)

 (d) \_\_\_\_\_\_ % Teaching/training (e.g., didactic teaching, precepting)

 (e) \_\_\_\_\_\_ % Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where applicable, please select the most appropriate description of the direct patient care service(s) offered in the community practice setting that involve the resident and residency program (1 = in development, 2 = pilot program, 3 = established program).
2. Medication Management (i.e., comprehensive and targeted) [ ]  Development [ ]  Pilot [ ]  Established
3. Health and Wellness Activities [ ]  Development [ ]  Pilot [ ]  Established
4. Disease State Management [ ]  Development [ ]  Pilot [ ]  Established
5. Care Transitions [ ]  Development [ ]  Pilot [ ]  Established
6. Patient-centered medication distribution [ ]  Development [ ]  Pilot [ ]  Established