## American Society of Health-System Pharmacists

## Accreditation Council for Pharmacy Education

# Academic and Professional Record

*For use with application for ASHP-ACPE Accreditation of Pharmacy Technician Education and Training Programs. Duplicate as needed.*

***Please type or print all information.***

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position or Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy or Pharmacy Technician School Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credential Received (e.g., certificate or degree):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year Graduated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year when State license or registration was first granted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State(s) in which licensed or registered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Year of national certification (indicate which certification exam) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Advanced Study

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **College** |  | **Location** |  | **Years Attended** |  | **Degree** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

### Advanced Training

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Institution** |  | **Location** |  | **Years** |
|  |  |  |  |  |
|  |  |  |  |  |

### Membership in Professional Societies

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| National Pharmacy Organization/Pharmacy Technician | | | \_\_\_\_\_\_ Yes | \_\_\_\_\_\_ No |  |
| Name(s) of Organization | | | \_\_\_\_\_\_ Yes | \_\_\_\_\_\_ No |  |
| Name: |  |  |  |  |  |
|  |  |  |  |  |  |
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### Experience in Pharmacy or Pharmacy Technician Practice During the Previous Ten Years

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Pharmacy** |  | **Location** |  | **Position & Title** |  | **Dates** |
|  |  |  |  |  |  |  |
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### contributions to advancement of pharmacy technician practice *(examples: publications; local, state, national presentations; community involvement)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Contribution** |  |  |  | **Dates** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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### Supplemental Data

Please use additional sheets if you want to submit other material pertinent to your record.